HEALTHCHECK SCREENING SERVICES
APPENDICES

APPENDIX 1
HEALTHCHECK LABORATORY AND IMMUNIZATION CODES

LABORATORY TESTS:

Code	Description
81002	Urinalysis, by dipstick . . ., without microscopy, non-automated
81005	Urinalysis and qualitative or semi-qualitative, except immunoassays
82465	Cholesterol, serum; total
82960	Glucose-6-phosphate dehydrogenase (G6PD); screen
83020	Hemoglobin, electrophoresis (e.g., A2, S, C)
84203	Protoporphyria, RBC; screen
84478	Triglycerides
84703	Gonadotropin, chorionic (hCG); qualitative
85014	Blood count; other than spun, hematocrit
85018	Blood count; hemoglobin
85660	Sickling with RHC, reduction, slide mount
86280	Hemagglutination inhibition test (HAI)
86287	Hepatitis B surface antigen (HBsAg)
86289	Hepatitis B core antibody (HBcAb); IgC and IgM
86291	Hepatitis B surface antibody (HBsAb)
86317	Immunoassay for infectious agent antibody, quantitative, not elsewhere specified
86580	Skin Test; tuberculosis, intradermal
86585	Skin Test; tuberculosis, tine test
86592	Syphilis Test, Qualitative (e.g., VDRL, RPR, ART)
86687	Antibody; HTLV I
86688	Antibody; HTLV II
86689	Antibody, HTLV or HIV antibody, condimatory test (e.g., Western Blot)
87045	Culture, bacterial, definitive; stool
87081	Culture, bacterial, screening only, for single organisms
87086	Culture, bacterial, urine; quantitative, colony count
87210	Smear, primary source, with interpretation; wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87220	Tissue examination for fungi (e.g., KOH slide)
88150	Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision
99000	Lab Handling Fee

IMMUNIZATIONS:

	Code	Description
*	90700	Diphtheria, tetanus toxoid, and acellular pertussis vaccine (DtaP)
*	90701[1]	DTP (diphtheria and tetanus toxoids and pertussis vaccine)
*	90702	DT (diphtheria and tetanus toxoids)
	90704	Mumps virus vaccine, live
	90705	Measles virus vaccine, live, attenuated
	90706	Rubella virus vaccine, live
*	90707[2]	MMR (measles, mumps and rubella virus vaccine, live)
	90708	MR (measles and rubella virus vaccine, live)
*	90712	Poliovirus vaccine, live, oral (any type) (OPV)
*	90718	Td (tetanus and diphtheria toxoids absorbed for adult use)
*	90720	DTP and Hib (Tetramune)
	90724	Influenza virus vaccine
*	90731	Hepatitis B vaccine
*	90737	Hib (Hemophilus Influenza B)
	90749	Unlisted immunization procedure
*	W7018[3]	DTP, MMR and Oral Polio
*	W7020	Hepatitis B Vaccine (HB [pediatric])

* Vaccine is provided through the VFC. Refer to Section II-L of this handbook for information on the VFC.

[1] May not be billed with procedure code 90702 or 90718.

[2] May not be billed with procedure codes 90704-90706 or 90708.

[3] May not be billed with procedure codes 90701, 90704-90708, or 90712.

APPENDIX 1a
HEALTHCHECK SCREENING CODES

❖ **Effective for claims, with claim sort indicator "H", received by the fiscal agent through 6/30/95**

COMPREHENSIVE SCREEN:

Code	Description
W7000	Comprehensive Screen

PARTIAL SCREEN (Do not use if billing the comprehensive code):

Code	Description
W7002	Vision
W7003	Hearing
W7009	Dental

INTERPERIODIC VISIT (follow-up on medically necessary issues between comprehensive screenings):

Code	Description
W7013	Brief Interperiodic (less than 15 minutes)
W7015	Intermediate Interperiodic (15 - 30 minutes)
W7016	Extended Interperiodic (over 30 minutes)

OTHER BILLABLE SERVICES

Code	Description
W7010	HealthCheck Pelvic Exam
W7083	Initial Lead Inspection (requires prior authorization)
W7084	Follow-up Lead Inspection (requires prior authorization)
W7017	Educational Visit After Lead Inspection (1 visit only allowed)

APPENDIX 1b
DEFINITIONS OF HEALTHCHECK SCREENING CPT CODES

❖ These codes may be used for claims received by the fiscal agent on and after 2/15/95. They must be used for all claims received on and after 7/1/95. Always use claim sort indicator "P".

Exam/Assessment
NEW PATIENT
Initial Evaluation[1]

CODE	DEFINITION
99381	Infant (under 1 year)
99382	Early Childhood (age 1 through 4 years)
99383	Late Childhood (age 5 through 11 years)
99384	Adolescent (age 12 through 17 years)
99385	Age 18 through 20 years

Exam/Assessment
ESTABLISHED PATIENT
Periodic Evaluation[1]

CODE	DEFINITION
99391	Infant (under 1 year)
99392	Early Childhood (age 1 through 4 years)
99393	Late Childhood (age 5 through 11 years)
99394	Adolescent (age 12 through 17 years)
99395	Age 18 through 20 years

Interperiodic Screens
(follow-up on medically necessary issues between comprehensive screens)

CODE	DEFINITION
W7013	Brief Interperiodic (less than 15 min)
W7015	Intermediate Interperiodic (15 - 30 min)
W7016	Extended Interperiodic (over 30 min)

[1] These codes require the use of HealthCheck modifier, if you did a comprehensive HealthCheck screen.

APPENDIX 1b (continued)
DEFINITIONS OF HEALTHCHECK SCREENING CPT CODES

Partial Screens

(do not use if billing a comprehensive code)

CODE	DEFINITION
W7002	Vision Screen
W7003	Hearing Screen
W7009	Oral Assessment

Other Billable Services

CODE	DESCRIPTION
W7010	HealthCheck Pelvic Exam
W7083	Initial Environmental Lead Inspection[1]
W7084	Follow-up Environmental Lead Inspection[1]
W7017	Educational Visit for Lead Poisoning[2]

[1]Requires prior authorization

[2]May only be billed when a prior authorization for lead inspection has been granted.

APPENDIX 2a
HEALTHCHECK REFERRAL/MODIFIER CODES

❖ These referral codes must only be used with "local" HealthCheck codes and only on claims received prior to 7/1/95

01 - No referral needed (test normal)

02 - Problem already under treatment

03 - Physician specialist (off site)

04 - Dentist

05 - Eye specialist

06 - Other specialist (May include referrals for HealthCheck "Other Services". Refer to Section II-F of this handbook for a description of HealthCheck "Other Services".)

07 - Social services agency

08 - Immunized on site

09 - Public health agency

10 - Headstart Program (Education)

11 - Mental Health/AODA Program

12 - Children with Special Health Care Needs Program

13 - Immunization (not on-site)

14 - WIC Program/Nutritionist (see Appendix 12 for WIC Referral Form)

15 - Hearing specialist (audiologist)

16 - Family Planning

17 - Prenatal Care Program

18 - Car safety Seat Program

19 - Early Intervention Services

20 - Developmental Disabilities Services

APPENDIX 2b
HEALTHCHECK REFERRAL/MODIFIER CODES

❖ Modifier and referral codes to be used with CPT code billing of comprehensive HealthCheck screens.

HealthCheck Nursing Agencies ONLY
(HealthCheck screener agencies such as local public health agencies)

HA Medical referral (other than dental, vision or hearing) is needed and a referral has been made, or the patient will return to this agency for follow-up.

HB Vision and/or hearing referral is needed and the referral to a specialist has been made.*

HC No medical referral (other than dental, vision or hearing) is needed, or treatment was provided during the screen.

All Other HealthCheck Providers
(Physicians, Independent Nurse Practitioners & Physician Assistants)

MR Medical referral (other than dental, vision or hearing) is needed and a referral has been made, or the patient will return to this practice for follow-up.

VH Vision and/or hearing referral is needed and the referral to a specialist has been made.*

NO No medical referral (other than dental, vision or hearing) is needed, or treatment was provided during the screen.

* If both the vision/hearing referral code and the medical referral code apply, use the medical referral code. This information is necessary for federal reporting.

APPENDIX 3
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR HEALTHCHECK SERVICES

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "H" for the service billed in the Medicaid check box when billing using local codes for claims received before 7/1/95. Enter claim sort indicator "P" when billing using CPT codes. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

NOTE: A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit Medical Assistance identification number.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Health insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed health insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA or OTH, and the service requires health insurance according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c and 9d are not required.)

Code	Description
OI-P	PAID in part by health insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by health insurance following submission of a correct and complete claim or payment was applied toward the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. May be used by hospitals, nursing homes and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (not required)

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN (not required)

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE
If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB
If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise, this element is not required.

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. When a specific medical diagnosis has not been determined, indicate diagnosis code V70.0 (routine general medical examination at health care facility). The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION (not required)

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 18a and 18b of this handbook for allowable place of service codes.

ELEMENT 24C - TYPE OF SERVICE CODE
Enter the appropriate single-digit type of service code. Refer to Appendix 18a and 18b of this handbook for allowable type of service codes.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to Appendix 1,1a and 1b of this handbook for a list of allowable procedure codes and to Appendix 2a and 2b for a list of allowable modifiers. See Appendices 18a and 18b for procedure codes with corresponding modifiers, place of service, type of service codes, and claim sort indicators.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if BOTH HealthCheck and family planning services were provided. If HealthCheck/family planning do not apply, leave this element blank.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33. This element is not required for HealthCheck nursing agencies.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 4a
SAMPLE HCFA 1500 CLAIM FORM
COMPREHENSIVE SCREEN WITH IMMUNIZATION, HEMOGLOBIN, AND LAB HANDLING FEE FOR LEAD SCREENING
CLAIM SORT INDICATOR "H"
RECEIVED BY THE FISCAL AGENT THROUGH 6/30/95
ANY HEALTH CHECK PROVIDER

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
[ ] (Medicare #) [H] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)			1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Im A	MM DD YY M [X] F [ ]		
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)
609 Willow St.	Self [ ] Spouse [ ] Child [ ] Other [ ]		
CITY / STATE	8. PATIENT STATUS		CITY / STATE
Anytown / WI	Single [ ] Married [ ] Other [ ]		
ZIP CODE / TELEPHONE (Include Area Code)	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]		ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
55555 / (XXX) XXX-XXXX			( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO		a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [ ] NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70.0 2. 3. 4.			22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 01 95	3	1	W7000	08	1	XX XX	1				
2 04 01 95	3	1	90707		1	XX XX	1				
3 04 01 95	3	1	90720		1	XX XX	1				
4 04 01 95	3	5	83020		1	XX XX	1				
5 04 01 95	3	5	99000		1	XX XX	1				
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]	26. PATIENT'S ACCOUNT NO. 1234JD	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO	28. TOTAL CHARGE $ XXX XX / 29. AMOUNT PAID $ / 30. BALANCE DUE $ XXX XX
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized SIGNED MM/DD/YY DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I. M. Billing 1 W. Williams Anytown, WI PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4b
SAMPLE HCFA 1500 CLAIM FORM
COMPREHENSIVE SCREEN WITH PROBLEM IDENTIFIED
CLAIM SORT INDICATOR "P"
RECEIVED BY EDS ON OR AFTER 2/15/95
PHYSICIAN BILLER

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) (Medicaid #) [P] (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] — Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 599.7 2. 3. 4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 15 95		3	1	99381	MR	1	XX XX	1				6543210
2 03 15 95		3	1	90712		1	XX XX	1				6543210
3 03 15 95		3	1	90720		1	XX XX	1				6543210
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.: 1234JD

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I. M. Authorized

SIGNED MM/DD/YY DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I. M. Billing
1 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4c
SAMPLE HCFA 1500 CLAIM FORM
COMPREHENSIVE SCREEN WITH PELVIC EXAM
CLAIM SORT INDICATOR "P"
RECEIVED BY EDS ON OR AFTER 2/15/95
PHYSICIAN BILLER

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE (Medicare #)	MEDICAID (Medicaid #) P	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
							1234567890		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Recipient, Im A			MM DD YY	M X F					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
609 Willow St.			Self Spouse Child Other						
CITY		STATE	8. PATIENT STATUS				CITY		STATE
Anytown.		WI	Single Married Other						
ZIP CODE	TELEPHONE (Include Area Code)		Employed Full-Time Student Part-Time Student				ZIP CODE	TELEPHONE (INCLUDE AREA CODE)	
55555	(XXX)XXX-XXXX							( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
OI-Y									
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX M F	
			YES NO						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M F		b. AUTO ACCIDENT?	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
			YES NO						
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES NO If yes, return to and complete item 9 a-d.		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____							13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____		
14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY		
19. RESERVED FOR LOCAL USE							20. OUTSIDE LAB? YES NO	$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) →							22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.	
1. V70.0 3.							23. PRIOR AUTHORIZATION NUMBER		
2. 4.									

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 04 95		3	1	99385	NO	1	XX XX	1				65432100
2 02 04 95		3	1	88150		1	XX XX	1				65432100
3 02 04 95		3	1	W7010		1	XX XX	1				65432100
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	1234JD		$ XXX XX	$	$ X XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Authorized MM/DD/YY SIGNED DATE		I. M. Billing 1 W. Williams Anytown, WI 55555 PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4d
SAMPLE HCFA 1500 CLAIM FORM
COMPREHENSIVE SCREEN
LEAD TEST GIVEN - BILL LAB HANDLING FEE
CLAIM SORT INDICATOR "P"
RECEIVED BY THE FISCAL AGENT ON OR AFTER 2/15/95
HEALTHCHECK NURSING AGENCY BILLER

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
☐ (Medicare #) ☐ P (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)	1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M ☐ F ☒
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street): 609 Willow St.	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY: Anytown — STATE: WI	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐
CITY — STATE	
ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX	ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-Y	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? ☒ YES ☐ NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70 0 — 2. — 3. — 4. —	22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1 04 01 95	3	1	99382	HC	1	XX XX	1				
2 04 01 95	3	5	99000		1	XX XX	1				
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☐ ☐	1234JD	☐ YES ☐ NO	$ XXX XX	$	$ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Authorized MM/DD/YY — SIGNED — DATE		I. M. Billing 1 W. Williams Anytown, WI 55555 PIN# — GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4e
SAMPLE HCFA 1500 CLAIM FORM
INTERPERIODIC SCREEN WITH IMMUNIZATION
CLAIM SORT INDICATOR "P"
RECEIVED BY THE FISCAL AGENT ON OR AFTER 2/15/95
HEALTHCHECK NURSING AGENCY BILLER

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 609 Willow St.	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street):
CITY: Anytown STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY: STATE:
ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-Y	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME:
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70 0 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 01 95	3	1	W7013		1	XX XX	1				
2 03 01 95	3	1	90718		1	XX XX	1				
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 1234JD	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ XX XX
29. AMOUNT PAID $	30. BALANCE DUE $ XX XX		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized SIGNED MM/DD/YY DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I. M. Billing 1 W. Williams Anytown, WI 55555 PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4f
SAMPLE HCFA 1500 CLAIM FORM
ENVIRONMENTAL LEAD INVESTIGATION AND INTERPERIODIC SCREEN
PRIOR AUTHORIZATION PREVIOUSLY APPROVED
CLAIM SORT INDICATOR "P"
RECEIVED BY THE FISCAL AGENT ON OR AFTER 2/15/95
HEALTHCHECK NURSING AGENCY BILLER

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) [ ] (Medicaid #) [P] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V70 0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 7654321

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 02 95		4	9	W7083		1	XX XX	1				
2 02 09 95		4	1	W7017		1	XX XX	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JD

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Authorized MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I. M. Billing
1 W. Williams
Anytown, WI 55555
PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4g
ELECTRONIC MEDIA CLAIMS SAMPLE SCREEN

HCFA 1500 (CT 20, 21, 22, 24, 30)

* *

MEDICAL ECS SCREEN
The field numbers on the ECS screen correspond with the numbered data elements on the HCFA 1500 claim form.

```
            WELCOME TO ELECTRONIC CLAIMS SUBMISSION          DATE 010193
                       EDS - WISCONSIN MEDICAID

BP NBR __33__ L NAME _____2_____  F NAME ____2____  MID ___1A___
PCN _____26_____   OI _9_  TPL _10_  MSC _11_  PA NBR __23__  LAB _20_
RP NBR _____17_____   FP NBR ___32___   OP NBR __________
DIAG 1 _21.1_  2 _21.2_  3 _21.3_  4 _21.4_  5 ______

DTL  FDOS     A1A2A3 POS  PROC   M1 M2 PP NBR  DX  CHARGE  UNIT  TOS EMG H/F

 1  __24.A__  ___A___ _B_ __D__  _D_ _D_ __K__ _E_ __F__  __G__ _C_ _I_ _H_
 2  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___
 3  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___
 4  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___
 5  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___
 6  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___
 7  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___
 8  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___
 9  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___
10  ________  _______ ___ _____  ___ ___ _____ ___ _____  _____ ___ ___ ___

  TOT BILL __28__  OI PAID __29__  PAT PAID _24.K_  NET BILL __30__

Doc #1   Page #1   Field #6   Form: MEDICAL            06-01-1992 10:16:34
```

Form	CT	Description
MEDICAL	20	Chiropractor Services Family Planning Clinics Rural Health Clinics Laboratory, X-ray, Radiology Free Standing Ambulatory Surgical Centers Physician Services Non-51.42 Owned & Operated Mental Health, AODA, Day Treatment Case Management Community Support Program Podiatry Services Prenatal Care Coordination HealthCheck

Department of Health and Social Services
Division of Health

APPENDIX 5
HEALTHCHECK PERIODICITY TABLE

HealthCheck should begin with a neonatal examination at birth whenever possible.
Recipients are limited, based on their age, to the following number of comprehensive screenings for a consecutive twelve month period:

- Birth to one year, 6 screenings
- Age one to two years, 3 screenings
- Age two to three years, 2 screenings
- Age three to twenty-one years, 1 screening/year

When medically necessary, additional visits may be billed as interperiodic visits.

I. Health Nutritional & Developmental Assessment / AGE 1	INFANCY						EARLY CHILDHOOD						LATE CHILDHOOD					ADOLESCENCE			
	By 1 mo.	2 mos.	4 mos.	6 mos.	9 mos.	12 mos.	15 mos.	18 mos.	24 mos.	30 mos.	3 yrs.	4 yrs.	5 yrs.	6-7 yrs.	8-9 yrs.	10-11 yrs.	12-13 yrs.	14-15 yrs.	16-17 yrs.	18-19 yrs.	20-21 yrs.
A. HISTORY 2	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
B. DEVEL/BEHAV ASSESSMENT 3	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
C.HEALTH EDUCATION/ ANTICIPATORY GUIDANCE 4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
II. Physical Assessment																					
A. MEASUREMENTS Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●											
Blood Pressure											●	●	●	●	●	●	●	●	●	●	●
B. UNCLOTHED PHYSICAL EXAMINATION	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
C.SENSORY SCREENING Vision	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hearing 5	●	●	●	●	●	●	●	●	●	●	●	●	●	●			●		●		
D. DENTAL 6											●	●	●	●	●	●	●	●	●	●	●
III. PROCEDURES DPT 7		●	●	●				●					●								
OPV		●	●					●					●								
MMR							●						●								
HbCV 8		●	●	●			●														
Td																		●			
Hematocrit/Hemoglobin 9					●				●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Lead 10 (Verbal Assessment)						●			●		●	●	●								
Pap Smear/Pelvic 11 HIV/Sickle Dex																					
12 Tuberculin Test																					
13 Urinalysis																					

Key: ● = to be performed

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time. This is especially important for children between the ages of 2 and 3.
2. Health history to include nutritional assessment.
3. By history and appropriate physical examination; if suspicious, by specific objective developmental testing.
4. Assessment of parent/child interaction and appropriate discussion and counselling should be an integral part of each visit for care.
5. Screen at birth through age 2 using both methods outlined in Appendices 14 and 14a. Children failing either screening method should be referred for audiological assessment.
Administer puretone audiometric screening as follows: Usually to all children 3-8 years old and at 4 year intervals thereafter up to age 16; to any child older than 8 who is receiving HealthCheck screening for the first time or has excessive noise exposure, delayed speech & language development.
6. For children under 3 years, question parents about problematic thumb sucking, lip biting, caries, tongue thrusting, non-erupted teeth, extra teeth, extended use of pacifier or bottle feeding practices. All children age 3 or older must be referred to a dentist, with subsequent or earlier exams as deemed medically necessary. (For this age group, six month dental check-ups are a covered benefit.)
7. These may be modified, depending on entry point into schedule and individual need.
8. Recommended by the Food and Drug Administration, Centers for Disease Control and American Academy of Pediatrics at two, four, and six months in addition to 15 months.
9. Present medical evidence suggests the need for reevaluation of the frequency and timing of hemoglobin or hematocrit tests. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
10. Lead verbal assessment to be done at each visit between the ages of nine months through 5 years. Blood lead testing as per chart in Appendix 13b.
11. As clinically indicated.
12. For low risk groups, the Committee on Infectious Diseases recommends the following options: 1) no routine testing or 2) testing at three times - infancy, preschool, and adolescence. For high risk groups, annual TB skin testing is recommended.
13. The frequency and timing of urinalysis is left to the individual practice experience.

APPENDIX 6
EFFECTIVE ORAL ASSESSMENT

Birth to Age 3 - Referral to Dentist
Referral of a child in this age group to the dentist may be appropriate. If oral problems are apparent, referral should follow.

Many dentists prefer to examine the child (and counsel the parents) by one year of age (ideally at about 9 months of age). This early dental visit enables the dentist and parents to discuss ways to nurture excellent oral health before any serious problems have had an opportunity to develop.

Early referral is indicated when:

- dietary fluoride supplements are necessary
- oral hygiene appears inadequate
- dietary practices are abnormal (Baby Bottle Tooth Decay potential)
- eruption of teeth are abnormal (delayed or crowded)
- dental disease is present

Age 3 and Above (refer all children for dental care)
Key questions for the parent of the infant or young child prior to oral assessment.

1. Does the child consume water with adequate levels of fluoride for prevention (birth to age 16). This is the most important question in relation to the prevention of future dental disease. If the child resides in a home with rural well water or in a community that fails to add fluoride to its water, then a referral to the dentist is necessary for a water analysis. A daily fluoride supplement may be needed to ensure adequate prevention of dental caries. A Wisconsin Community Fluoridation Census will aid in determining the fluoridation status of community water systems.

2. Has child been to the dentist?

3. Does the parent brush or assist in brushing the child's teeth?

4. Does the child sleep with the bottle or carry the bottle during the day?

5. Does the child have any dental problems, concerns or complaints?

6. Have any brothers or sisters had dental problems?

Wisconsin Community Fluoridation census is available from:

Bureau of Public Health
Attn: Oral Health Consultant
1414 E. Washington Avenue
Madison, WI 53703-3044

Oral Assessment Instruction Detail is available from:

Bureau of Health Care Financing
Attn: HealthCheck Coordinator
Post Office Box 309
Madison, WI 53701

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Health
DOH-1002 (Rev.3/91)

APPENDIX 7

HEALTHCHECK INDIVIDUAL HEALTH HISTORY

Fill out one form for each person screened	CURRENT MEDICAL ASSISTANCE I.D. NUMBER PER CODE DATE COMPLETED / /
NAME OF PATIENT	NAME OF PARENT OR GUARDIAN
ADDRESS	ADDRESS
PHONE	PHONE
BIRTHDATE	SCHOOL AND GRADE OR OCCUPATION
PHYSICIAN NAME AND ADDRESS	
DENTIST NAME AND ADDRESS	

GENERAL HEALTH *(Answer for All Ages)*

Office Use	Yes	No	Don't Know	
1				Has it been more than 12 months since this person had a general checkup by a physician?
2				Has it been more than 12 months since a physician examined this person because of illness or injury?
3				Has it been more than 12 months since this person had a general checkup by a dentist?
4				Has it been more than 12 months since a dentist exa mined this person because of pain of injury?
5				Is there anything about this person's health, growth or development that you are concerned or worried about? If YES, explain.
6				Does this person always use a seatbelt or carseat in an automobile?

DID THIS PERSON EVER HAVE OR DOES THIS PERSON NOW HAVE ANY OF THE FOLLOWING?

Office Use	Yes	No	Don't Know		Office Use	Yes	No	Don't Know	
7				Unexplained fever	20				Vomiting or diarrhea
8				Poor appetite or feeding problem	21				Wheezing or noisy breathing
9				Loss of weight	22				Swollen joints
10				Loss of consciousness, fainting	23				Heart murmur
11				Head Injury	24				Frequent stomach aches
12				Seizure, convulsions, fits	25				Blood in bowel movements
13				Frequent headaches	26				Bladder, kidney, or urinary problems
14				Eye trouble	27				Blood in urine
15				Earaches, draining ears	28				Rashes, eczema, hives, skin problems
16				Frequent nosebleeds	29				Many bruises or bleedings
17				Chronic cough	30				Frequent stumbling, falling
18				Hearing problems	31				Frequent colds or infections
19				Constipation					

APPENDIX 7
HEALTHCHECK INDIVIDUAL HEALTH HISTORY FORM
(continued)

Office Use	Yes	No	Don't Know	HAS THIS PERSON HAD ANY OF THE FOLLOWING?
32				
				Rubella (German measles)
				Measles (Red)
				Mumps
				Rheumatic fever
33				Did or does this person have allergies? If YES, describe.
34				Did or does this person have asthma?
35				Has this person had any serious accidents? If YES, describe.
36				Has this person had any hospitalizations, operations, major illness? If YES, describe.
37				Does this person now have any problems which you feel, or which a physician has told you, may be related to any one of the conditions 7 - 36? If YES, describe.
38				Does this person OFTEN eat things which are not usually considered to be food? (Example: dirt, paint,chips, crayons, clay, starch, newspaper.) If YES, describe.
39				Does this person have problems with toileting or toilet training?
40				Does this person get along with family members and playmates?
41				Does this person have difficulty learning?
42				Does this person get into trouble in school or dislike school?
43				Has this person taken prescription medicines in the last 12 months? For what?
44				Has this person taken non-prescription medicines in the last 12 months? (Example: aspirin, antihistimines, vitamins, food supplements.) What?
45				Has this person ever had a positive reaction to a tuberculosis test?
46				Referred for Adolescent Review
47				ANSWER FOR FEMALES BORN BEFORE 1972: Did the mother of this person take any medications to prevent miscarriage during this pregnancy?

IMMUNIZATION HISTORY: Please give the date this person received each of the following:

Type[Recommended Doses]	None	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTP (Diptheria, tetanus, and whooping cough) [5 doses by school entrance]						
Td (Tetanus) [every 10 years after school entrance]						
Polio Oral (by mouth) [4 doses by school entrance]						
Measles, Mumps, Rubella [2 doses by school entrance]						
Hemophilus Influenza, type b [at 2, 4, 6 and15 months]						

APPENDIX 7
HEALTHCHECK INDIVIDUAL HEALTH HISTORY FORM
(continued)

BEHAVIORAL/EMOTIONAL HEALTH

OFFICE USE	YES	NO	DON'T KNOW	
47				Does this person have a history of either: ● behavioral or emotional problems OR ● treatment for behavioral or emotional problems at a ● clinic or hospital? If YES for any, explain.
48				Has anyone in this person's family ever been treated or hospitalized for emotional problems such as: depression, anxiety, mood swings, suicide attempts, or alcohol or drug abuse? If YES for any, explain.
49				Has this person ever abused alcohol and/or drugs? If YES, explain.

50 Has this person ever:

( ) felt hopeless or depressed
( ) had unexplained crying spells
( ) planned or attempted suicide
( ) had peculiar or bizarre thoughts
( ) had trouble eating or sleeping [too much or too little]
( ) had an excess of energy or activity
( ) felt like hurting him/her self
( ) displayed reckless or dangerous behavior
( ) heard things no one else around them heard
( ) show inappropriate emotions [reactions that don't make sense for the situation]

51 Does this person have any of these problems at school?

( ) poor grades
( ) difficulty in making friends
( ) frequent suspensions from school
( ) fighting or arguing with peers or teachers
( ) frequently lying or stealing
( ) frequent cutting classes or playing hooky

52 Has this person had any of the following problems at home or in the community?

( ) withdrawing socially [doesn't want to be around other people]
( ) lying or stealing
( ) arguing or fighting with peers or brothers or sisters
( ) clinging excessively to a parent, teacher, or other person
( ) running away from home
( ) problems with police
( ) refusing to follow instructions from parents, or obey the house rules, etc.

Criteria For Referral For Further Assessment:

47. and 49. Refer for a psychiatric assessment if there is a positive response.
48. Refer only if referred criteria are met for any other question.
50. Refer for a psychiatric assessment if any responses are checked.
51. and 52. Refer for a psychiatric assessment if two or more responses are checked.

APPENDIX 7
HEALTHCHECK INDIVIDUAL HEALTH HISTORY FORM
(continued)

PREGNANCY & DEVELOPMENT

(Answer for all Ages)

BIRTH ORDER of this person. Indicate by circling whether this person was the first, second, etc. Do not count still-born brothers or sisters.

1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th or over

MOTHER'S AGE AT THIS BIRTH	Circle one.	Under 17	17 - 39	40 and over	Unknown		
FATHER'S AGE AT THIS BIRTH	Circle one.	Under 17	17 - 39	40 and over	Unknown		

53	Yes	No	Don't Know	**MOTHER'S PREGNANCY HISTORY** *(Answer only for children UNDER 6 YEARS)*
				Was there any bleeding during this pregnancy?
				Was the baby born early? If so, how many weeks?
				Was there other difficulty or illness during this pregnancy? (Examples: rubella or german measles, high blood pressure, high blood sugar, sexually transmitted disease, etc.) If YES, describe.
				Were any X-rays taken during pregnancy?
				Were any prescription or other drugs taken during pregnancy? (Examples: tranquilizers, antibiotics, sedatives, medicines for vomiting, medicines - shot or oral - to prevent miscarriage or bleeding.) If YES, describe.
				Were any non-prescription medications taken during pregnancy? (Examples: vitamins, iron supplements, frequent aspirin, etc.) If YES, describe.
				Was there anything unusual about the labor or delivery? If YES, describe.
54				**DEVELOPMENTAL MILESTONES** *(Answer only for children UNDER 6 YEARS)*

Birthweight _____lbs. _____ozs. Length _____inches

Check the appropriate time this child did each of the following:

Follow object with eyes:
____ Not yet
____ Before one month
____ 1 - 4 months
____ After 4 months

Roll over:
____ Not yet
____ Before 2 months
____ 2 - 5 months
____ After 5 months

Turn to voice:
____ Not yet
____ Before 3 months
____ 3 - 8 months
____ After 8 months

Sit alone
____ Not yet
____ Before 5 months
____ 5 - 9 months
____ After 9 months

Act shy with strangers
____ Not yet
____ Before 5 months
____ 5 - 10 months
____ After 10 months

Walk alone:
____ Not yet
____ Before 11 months
____ 11 - 15 months
____ After 15 months

Speak single word:
____ Not yet
____ Before 9 months
____ 9 - 12 months
____ After 12 months

Speak simple sentences:
____ Not yet
____ Before 20 months
____ 20 mo - 2 1/2 years
____ After 2 1/2 years

Eat finger food alone:
____ Not yet
____ Before 2 years
____ After 2 years

Use cup alone:
____ Not yet
____ Before 2 years
____ After 2 years

Permission is hereby granted for health screening for early detection of health problems for _____
(NAME OF PATIENT)
and for the release of resulting information to appropriate health care providers and health authorities. Permission is also granted to such health care providers and health authorities to release information to personnel conducting this health screening program.

Date ___/___/___ Signature and relationship to patient _____

APPENDIX 8a
AGE-SPECIFIC HEALTHCHECK FOOD RECORDS

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Division of Health
DOH 1066 (3/94)

STATE OF WISCONSIN
Completion of this form is voluntary
1-800-722-2295

INFANT'S FOOD RECORD (0-12 months of age)

Name _____ Date _____

Directions: Write down everything baby ate or drank in the last 24 hours (meals and snacks). Start with the first morning feeding yesterday to the first morning feeding today.

Example:

3:00 am	home	breastfed
7:00 am	home	breastfed
9:00 am	sitter	3 ounces SMA with Iron, concentrate (made with 1 can concentrate and 1 can water)

TIME	PLACE	AMOUNT AND FOOD/BEVERAGE EATEN

Office Use Only: oz formula: #BF: Brd: Veg: Frt: Meat:

1. Is this the way your baby eats most of the time? ___ No ___ Yes If no, why not? _____

2. What is fed to baby in a bottle? ___ breast milk ___ formula ___ juices ___ water ___ cereal ___ milk ___ jello water ___ tea ___ other: _____

3. Check any problems baby has during feedings:
   ___ chokes and gags ___ is a fussy eater ___ other: _____

4. Where does baby's drinking water come from? ___ well ___ city water ___ bottled water ___ don't know

5. How often does baby go to a babysitter or day care? ____ days a week ___ never
   If baby goes to sitter or day care, are meals/food provided? ___ No ___ Yes

6. When you are short of money for baby's food or formula, what do you do? _____

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Division of Health
DOH 1066A (3/94)

STATE OF WISCONSIN
Completion of this form is voluntary
1-800-722-2295

CHILD'S FOOD RECORD (1-12 years of age)

Name _____ Date _____

Directions: Write down everything the child ate or drank in the last 24 hours (meals and snacks). Start with the first morning feeding yesterday to the first morning feeding today.

Example: 8:30 am home sandwich - 2 slices whole wheat bread, 2 slices cheddar cheese, and 1 tablespoon butter
1 cup tomato soup made with 2% milk

TIME	PLACE	AMOUNT AND FOOD/BEVERAGE EATEN

Office Use Only: Brd: Veg: Frt: Milk: Meat:

1. Is this the way this child eats most of the time? ___ No ___ Yes If no, why? _____
2. What foods does this child refuse to eat? _____
3. How often does this child eat away from home? ___ 1 to 2 times a week
   ___ 2 to 4 times a week ___ almost every day Where are these meals eaten?_____
4. Are mealtimes with this child usually pleasant? ___ No ___ Yes If no, why? _____
5. How many times in the last month did the child have problems getting enough food? _____

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Division of Health
DOH 1066B (3/94)

STATE OF WISCONSIN
1-800-722-2295
Completion of this form is voluntary

ADOLESCENT'S FOOD RECORD (13-20 years of age)

Name _____ Date _____

Directions: Write down everything you had to eat or drink, and how much, in the last 24 hours (meals and snacks). Start with the first time you ate yesterday, to the first time you ate today.

Example: 10:30 home donut, 4 oz apple juice

noon home sandwich - 2 slices whole wheat bread, 2 slices cheddar cheese, 1 tablespoon butter
1 cup (8 ounces) tomato soup made with 2% milk

TIME	PLACE	AMOUNT AND FOOD/BEVERAGE EATEN

Office Use Only: Bread: Veg: Frt: Milk: Meat:

1. Is this the way you eat most of the time? ___ No ___ Yes If no, why? _____
2. What foods do you refuse to eat? _____
3. How often do you eat away from home? ___ 1 to 2 times a week ___ 2 to 4 times a week
   ___ almost every day Where are these meals eaten? _____
4. Are you on a diet, following diet restrictions, or trying to control your weight? ___ No ___ Yes
5. How many times in the last month did you have problems getting enough food? _____

APPENDIX 8b

THE MODIFIED BASIC FOUR FOOD GROUPS

FOOD NEEDS FOR CHILDREN		SUGGESTED SERVING SIZES			
FOOD	NUMBER OF DAILY SERVINGS	1-3 YRS.	4-6 YRS.	7-14 YRS.	TEENS & ADULTS
Milk or Milk Products	**3 or more servings**				
— Whole*, low or nonfat milk as a beverage or in food preparation, yogurt		2/3 c.	3/4 c.	1 c.	1 c.
— Cheese		1 oz	1 oz	1 oz	1 oz
* Recommended for children under 2 years of age					
Fruits and Vegetables	**4 or more servings**	4-6 tbs	1/4-1/2 c.	1/2 c.	1/2 c.
— Vitamin C: citrus fruit or juice, tomatoes, broccoli, green pepper, berries	At least 1 serving				1 c. raw
— Dark greens: Dark leafy lettuce, greens, garden cress, watercress, bok choy, Brussel sprouts, cabbage, spinach, kale, swiss chard	At least 1 serving				
— Other fruits and vegetables	2 servings				
Protein Foods	**4 or more servings**				
— Animal:	2 or more servings				
Meat, fish, poultry		1/2-1 oz	1-2 oz	2-3 oz	3 oz
Egg		1	1	1	2
— Plant:	2 or more servings				
Dried peas, beans, lentils		2-4 tbs	1/4-1/2 c.	1/2-3/4 c.	3/4 c.
Soybean curd (tofu)		2 tbs	2-4 tbs	1/4 c.	1/4 c.
Peanut butter		1 tbs	1-2 tbs	2 tbs	2 tbs
Textured soy protein		1 tbs*	1-2 tbs	2 tbs	2 tbs
Nuts or seeds		1 tbs**	1-2 tbs	2 tbs	2 tbs
Whole Grain Bread & Cereals	**4 or more servings**				
— Breads (made with whole wheat, rye, oats, commeal, etc.), cooked whole grain		1/2-1 slice	1 slice	1 slice	1 slice
— Cooked whole grain cereals: oatmeal, wheat, buckwheat, rice, cereals with wheat germ; brown rice or whole grain pasta products		4-6 tbs	1/4-1/2 c.	3/4 c.	1/2 c.
— Dry whole grain cereals: shredded wheat, rice, oats, wheat or bran flake		1/2 oz	1/2-1 oz	1 oz	1 oz
— Wheat germ or bran		1 tsp	2 tsp	1 tbs	1 tbs
Fats and Oils	**1-2 servings**				
— Oils, shortenings, salad dressings, cream, sour cream, butter, bacon, fortified margarine, cream cheese		1 tsp	2 tsp	1 tbs	1 tbs

* Creamy only

** Use only finely ground or chopped to avoid choking

Additional food needs for pregnant and breastfeeding women include 4 or more adult servings of milk or milk products.

DAILY FOOD SUGGESTIONS FOR INFANTS

These suggestions are guidelines. They are daily totals not individual meal portions. Introduction of cereals should occur when the infant is developmentally ready. In addition, babies differ in food preferences and in quantities consumed.

AGE OF INFANT	BREAST MILK OR IRON-FORTIFIED INFANT FORMULA	ENRICHED AND WHOLE-GRAIN BREADS AND CEREAL		FRUITS AND VEGETABLES		MEAT,POULTRY, FISH, LEGUMES	YOGURT, COTTAGE CHEESE, ICE CREAM, PUDDING, EGG YOLK
		INF. CEREAL (DRY)[1]	BREAD, RICE, PASTAS	FRUITS/ VEGETABLES	INFANT JUICE[2]		
BIRTH-MONTH 5	ONLY						
MONTH 6	30 - 50 oz	3 - 5 tbsp	1/2 slice toast (for teething)[3]		2 - 6 oz		
MONTH 7	30 - 32 oz	3 - 5 tbsp	1/2 slice toast (for teething)[3]	2 - 5 tbsp	2 - 6 oz		
MONTH 8	29 - 31 oz	5 - 9 tbsp	1/2 slice toast (for teething)[3]	1/2 - 1 c or 1 - 2 jars fruits & vegetables	2 - 6 oz		
MONTH 9	26 - 31 oz	6 - 12 tbsp	1 slice toast	1/2 - 1 c fruits & vegetables	2 - 6 oz	1 tbsp	
MONTH 10	24 - 32 oz	1/2 - 3/4 c	1 slice or 1/2 - 3/4 c. cooked grain	3/4 - 1 1/4 c	2 - 6 oz	1 - 2 tbsp	1 - 2 tbsp
MONTH 11	24 - 32 oz	1/2 - 3/4 c	1 slice or 1/2 - 3/4 c. cooked grain	3/4 - 1 1/4 c	2 - 6 oz	1 - 2 tbsp	1 - 2 tbsp
MONTH 12	24 - 32 oz	1/2 - 3/4 c	1 slice or 1/2 - 3/4 c. cooked grain	3/4 - 1 1/4 c	2 - 6 oz	1 - 2 tbsp	1 - 2 tbsp

[1] Iron-fortified infant cereals are recommended as the first solids introduced. Rice cereal is commonly introduced first because of its low allergic potential. Cereals may be mixed with breast milk or formula to help the infant adjust to the new texture and taste.

[2] Juice can be given when the baby can drink from a cup; juice should not be given by bottle.

[3] If allergies run in the family, do not give your baby wheat products until approximately 8 months of age.

APPENDIX 9

Department of Health & Social Services
Division of Health
DOH-1062 (10/90)

HEALTHCHECK ADOLESCENT REVIEW

To be handed to adolescents 12 and over at the screening clinic.

Sometimes it is easier to talk about things this way. If you wish, circle YES or NO for each question and give this paper to the nurse... It will be returned to you.

1. Do you think something is wrong with your general health?	YES	NO
2. Do you feel you have to exercise more than 1 hr every day or else you feel bad about yourself?	YES	NO
3. Are you often upset?	YES	NO
4. Do you think something is wrong with your body development?	YES	NO
5. Do you think something is wrong with your weight and have you tried to lose or gain weight? How? _____	YES	NO
6. Is something slowing your progress in school?	YES	NO
7. Is something slowing your progress at work?	YES	NO
8. Are you having difficulties at home?	YES	NO
9. Do you have difficulty making friends when you are out?	YES	NO
10. Do you think something is wrong with your sex feelings?	YES	NO
11. Do you think something is wrong with your heart?	YES	NO
12. Do you think something is wrong with your skin?	YES	NO
13. Do you think something is wrong with your eyes?	YES	NO
14. Do you cough much or have breathing trouble?	YES	NO
15. Are you concerned about your stomach or bowels?	YES	NO
16. Do you think you have cancer? Where? _____	YES	NO
17. Does it "burn when you urinate?"	YES	NO
18. Do you have muscle or joint pain?	YES	NO
19. Do you have questions about drinking or use of drugs?	YES	NO
20. Do you have questions about pregnancy or birth control?	YES	NO
21. Do you have questions about discharge from your sex organs or sexually transmitted diseases?	YES	NO
22. Do you have questions about masturbation?	YES	NO

23. If you have questions or concerns about any of the following, we will be able to give you places and/or names to contact for further answers:

1 Dating, Going Steady	2 School Problems	3 Birth Control	4 Pregnancy
5 Drugs	6 Abortion	7 Sexually Transmitted Diseases	8 Weight Control

MALES ONLY

24. Do you have concerns about "wet dreams?"	YES	NO
25. Do you have concerns about size of your sex organ?	YES	NO

FEMALES ONLY

26. Have you started your periods? When _____ When was your last period? _____	YES	NO
27. How often do you get them? _____		
28. Do you have problems with your periods?	YES	NO
29. Do you take any medicine for them?	YES	NO
30. Have you ever had problems with a discharge, bleeding or anything else between your periods?	YES	NO
31. Please answer the following if you think you are pregnant:		
Do you live in a house built before 1950 where there is paint peeling?	YES	NO
Do you have a hobby that includes lead bullets, lead weights for fishing or lead glass?	YES	NO
Do you eat non-food items such as clay dirt, azarcon, Pay-loo-ah or Greta?	YES	NO

ANY OTHER COMMENTS OR QUESTIONS?

APPENDIX 10

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Division of Health
DOH-1063 (11/91)

HEALTHCHECK FAMILY HISTORY

NAME OF RECIPIENT

FAMILY MEMBERS - LIVING OR DEAD
(List natural or blood relatives)

PRESENT OR PAST ILLNESS *For each person, check those which apply. Use NOTES section for additional information.*	Father (natural)	Mother (natural)										Any of the Grandparents
YEAR OF BIRTH												
AUTISM												
ALCOHOLISM (Drinking Problem)												
ALLERGIES OR ASTHMA												
BEHAVIORAL DIFFICULTIES												
BIRTH DEFECTS												
CANCER												
DIABETES												
EPILEPSY												
HEARING DISABILITIES												
HEART ATTACK UNDER AGE 40												
HIGH BLOOD CHOLESTEROL												
HIGH BLOOD PRESSURE												
LEARNING DIFFICULTIES												
MENTAL ILLNESS												
MENTAL RETARDATION												
NEED FOR SPECIAL EDUCATION												
SPEECH & LANGUAGE PROBLEMS												
VISION DIFFICULTIES												
DECEASED AGE												

CAUSE

NOTES: (Other Illnesses, Disabilities Or Conditions That Run In Your Family That You Are Concerned About)

OTHER SIGNIFICANT INFORMATION:

APPENDIX 11
HEALTHCHECK REFERRAL FORM

DATE OF SCREENING: _____

RECIPIENT NAME: _____ MA-ID # _____

DATE OF REFERRAL APPOINTMENT: _____

REASON FOR REFERRAL: _____

REFERRED TO: _____

_____

_____
Provider Name, Address and/or Specialty

COMMENTS: _____

_____

_____

_____

SIGNATURE: _____ DATE: _____
Screening Provider

APPENDIX 11A
HEALTHCHECK VERIFICATION CARD

FRONT

HEALTHCHECK CARD

This verifies that Ima Recipient (name) received a comprehensive HealthCheck screening on 7/1/93 (date).

Your child should receive needed medical or dental follow-up services recommended by your HealthCheck provider. To get follow-up services, like dental sealants, you will need to show this card to the service provider. Take it with you to your child's medical and dental appointments.

This card is good for one year.

Anytown Clinic (Place of Service) J. M. Provider (Provider Signature)

Department of Health and Social Services • Division of Health DOH 1112 (2/93)

BACK

PREVENTION PAYS.

Call for your next appointment MM/DD/YY (date)

Comprehensive Screenings include:

- Health and Developmental Check
- Physical Exam
- Vision Test
- Hearing Test
- Oral Assessment
- Needed Shots/Immunizations
- Lab Tests

APPENDIX 12a

Department of Health & Social Service
Division of Health
DOH 4024 (Rev 3/86)

State of Wisconsin

WIC MEDICAL REFERRAL FORM
FOR

☐ Infant (to 1 yr.) ☐ Child (1-5 yrs)

PATIENT'S NAME _____ PARENT/CARETAKER'S NAME _____

ADDRESS _____

PHONE _____ BIRTHDATE _____ AGE _____ SEX: _____MALE _____FEMALE

The following information is required for referral to the WIC Program:

Present wt: _____	Hct: _____ % and/or	Infants Only:
Present lgth/ht: _____	Hgb: _____ gm	Birthweight: _____ lbs. _____ oz.
Date taken: _____	Date taken: _____	Birthlength: _____ in. _____ 8ths.
		Gestational age: _____ wks.

Vitamin/Mineral Rx: _____ Formula/Milk Rx: _____

Please check (✓) any medical/nutritional condition which might (or has) influenced the health of this child.

- ☐ Lead poisoning
- ☐ Birth injury (i.e. cleft lip/palate)
- ☐ Frequent infections
  - _____ number of colds in last 6 months
  - _____ number of otitis media in last 6 months
  - _____ number of throat infections in last 6 months
- ☐ Diabetes, CP, CF
- ☐ Severe dental problems
- ☐ Clinical signs of nutrient deficiency:
  _____

Additional Diagnoses/Health Concerns: _____

_____

_____

Physician or Health Professional's Name _____

Address: _____

_____ Phone: _____

Medical Office/Clinic: _____

Signature: _____ Date: _____

Final eligibility is based on a combination of nutritional, financial and medical criteria which will be determined by the local WIC Project.

This is an Equal Opportunity Program. If you believe you have been discriminated against because of age, race, color, handicap, sex, creed, national origin, ancestry, sexual orientation, arrest or conviction record, marital status, or religion, write immediately to your local WIC project. If you are not satisfied or if you do not get a response in approximately 30 days, write to DHSS, Affirmative Action/Civil Rights Compliance Office, P.O. Box 7850, Madison, WI 53707.

LOCAL WIC PROJECT:

APPENDIX 12b

WIC MEDICAL REFERRAL FORM

FOR

☐ Pregnant Woman ☐ Breastfeeding Woman

PATIENT'S NAME _____

ADDRESS _____

PHONE _____ BIRTHDATE _____ AGE _____

The following information is required for referral to the WIC Program:

ALL WOMEN:	ALL WOMEN:	PREGNANT:	BREASTFEEDING:
Present wt: _____	Hct: _____ % and/or	E.D.C. _____	Del. date: _____
Present ht: _____	Hgb: _____ gm	Wks gest: _____	Gest. age: _____ wks.
Date taken: _____	Date taken:	Prepreg. wt.: _____ lbs.	Wt. gained: _____ lbs.
Vit/Min Rx: _____	_____	Wt. gained: _____ lbs.	Prepreg. wt.: _____ lbs.

Please check (✓) any medical/nutritional condition which might (or has) influenced the outcome of this pregnancy.

- ☐ Lead poisoning
- ☐ Previous stillbirth, miscarriage, abortion
- ☐ Previous premature delivery
- ☐ Multiple birth or fetus
- ☐ Chronic disease: _____
- ☐ Hypertension, diabetes
- ☐ Late entry to OB care (after 1st trimester)
- ☐ Substance abuse: _____
- ☐ Therapeutic diet ordered: _____

Additional Diagnoses/Health Concerns: _____

_____

_____

Physician or Health Professional's Name _____

Address: _____

_____ Phone: _____

Medical Office/Clinic: _____

Signature: _____ Date: _____

Final eligibility is based on a combination of nutritional, financial and medical criteria which will be determined by the local WIC Project.

This is an Equal Opportunity Program. If you believe you have been discriminated against because of age, race, color, handicap, sex, creed, national origin, ancestry, sexual orientation, arrest or conviction record, marital status, or religion, write immediately to your local WIC project. If you are not satisfied or if you do not get a response in approximately 30 days, write to DHSS, Affirmative Action/Civil Rights Compliance Office, P.O. Box 7850, Madison, WI 53707.

LOCAL WIC PROJECT:

THANK YOU FOR YOUR COOPERATION

APPENDIX 13
WISCONSIN LEAD TESTING RESOURCES

Paint Testing and Environmental Evaluation:

Milwaukee Health Department, Environmental Health Unit evaluates lead hazards in Milwaukee residences where children have elevated blood lead levels: (414) 278-3538.

Local/county health departments may have limited capability to analyze lead in paint.

State Lab of Hygiene Toxicology Lab (608) 263-8160 and Milwaukee City Health Department (414) 278-3526 can test paint chips for lead content.

Blood:

Blood samples can be taken at any medical practice and in some local public health agencies and WIC clinics. For diagnostic blood lead analysis, these laboratories participate in national proficiency programs and have considerable experience:

State Lab, Toxicology	(608) 262-1146
West Allis Hospital Laboratory	(414) 546-6313
Milwaukee City Health Department	(414) 278-3526
Milwaukee Children's Hospital	(414) 266-2500
Marshfield Clinics	(715) 387-5317

Many of these labs, particularily the State Lab and Milwaukee City Health Department, provide advice on screening and blood testing.

Water: UW State Laboratory of Hygiene: (608) 262-1293
Department of Natural Resources certifies labs for water testing: (608) 266-0821 or DNR district offices.

Soil: UW Soils Lab: Madison (608) 262-4364 Milwaukee (414) 229-4894

Pottery: State Lab: (608) 262-1146
Milwaukee City Health Department Lab: (414) 278-3526

Occupational Exposures:

U.S. Department of Labor OSHA:	Milwaukee	(414) 297-3315
	Appleton	(414) 734-4521
	Madison	(608) 264-5388
	Eau Claire	(715) 832-9019

Wisconsin Division of Health: (608) 266-9383
Milwaukee City Health Department: (414) 278-3538

Home Testing Equipment for Pottery and Painted Surfaces:

Frandon:	(800) 359-9000
Hybrivet:	(800) 262-LEAD
BGI:	(617) 891-9380

General Information:

Wisconsin Division of Health: (608) 266-5885; regional offices or your local or county health department.

APPENDIX 13a
REPRINTED FROM PREVENTING LEAD POISONING IN YOUNG CHILDREN
A STATEMENT BY THE CENTERS FOR DISEASE CONTROL - OCTOBER, 1991

Screening Schedule

The following sections provide a minimum screening schedule for children aged 6 up to 36 and 36 to 72 months. The schedule is not rigid. Rather, it is a guide for pediatric health-care providers and screening programs to use in conjunction with other pertinent information in determining when an individual child should be tested.

Children six up to 36 months of age:

A questionnaire should be used at each routine office visit to assess the potential for high-dose lead exposure and, therefore, the appropriate frequency of screening.

- ***Schedule if the child is at low risk for high-dose lead exposure by questionnaire:***

  A child at low risk for exposure to high-dose lead sources by questionnaire should have an initial blood lead test at 12 months of age.

  If the 12-month blood lead result is **<10 μg/dL**, the child should be retested at 24 months if possible, since that is when blood lead levels peak.

  If a blood lead test result is **10-14 μg/dL**, the child should be retested every three to four months. After two consecutive measurements are < 10 μg/dL or three are <15 μg/dL, the child should be retested in a year.

  If any blood lead test result is **≥15 μg/dL**, the child needs individual case management, which includes retesting the child at least every three to four months.

- ***Schedule if the child is at high risk for high-dose lead exposure by questionnaire:***

  A child at high risk for exposure to high-dose lead sources by questionnaire should have an initial blood lead test at six months of age.

  If the initial blood lead result is **<10 μg/dL**, the child should be rescreened every six months. After two subsequent consecutive measurements are <10 μg/dL or three are <15 μg/dL, testing frequency can be decreased to once a year.

  If a blood lead test result is **10-14 μg/dL**, the child should be screened every three to four months. Once two subsequent consecutive measurements are <10 μg/dL or three are <15 μg/dL, testing frequency can be decreased to once a year.

  If any blood lead test result is **≥15 μg/dL**, the child needs individual case management, which includes retesting the child at least every three to four months.

Children ≥36 months and <72 months of age:

As for younger children, a questionnaire should be used at each routine office visit of children from 36 to 72 months of age. Any child at high risk by questionnaire who has not previously had a blood lead test should be tested. All children who have had venous blood lead tests ≥15 μg/dL or who are at high risk by questionnaire should be screened at least once a year until their sixth birthday (age 72 months) or later, if indicated (for example, a developmentally delayed child with pica). Children should also be rescreened any time history suggests exposure has increased. Children with blood lead levels ≥15 μg/dL should receive followup as described below.

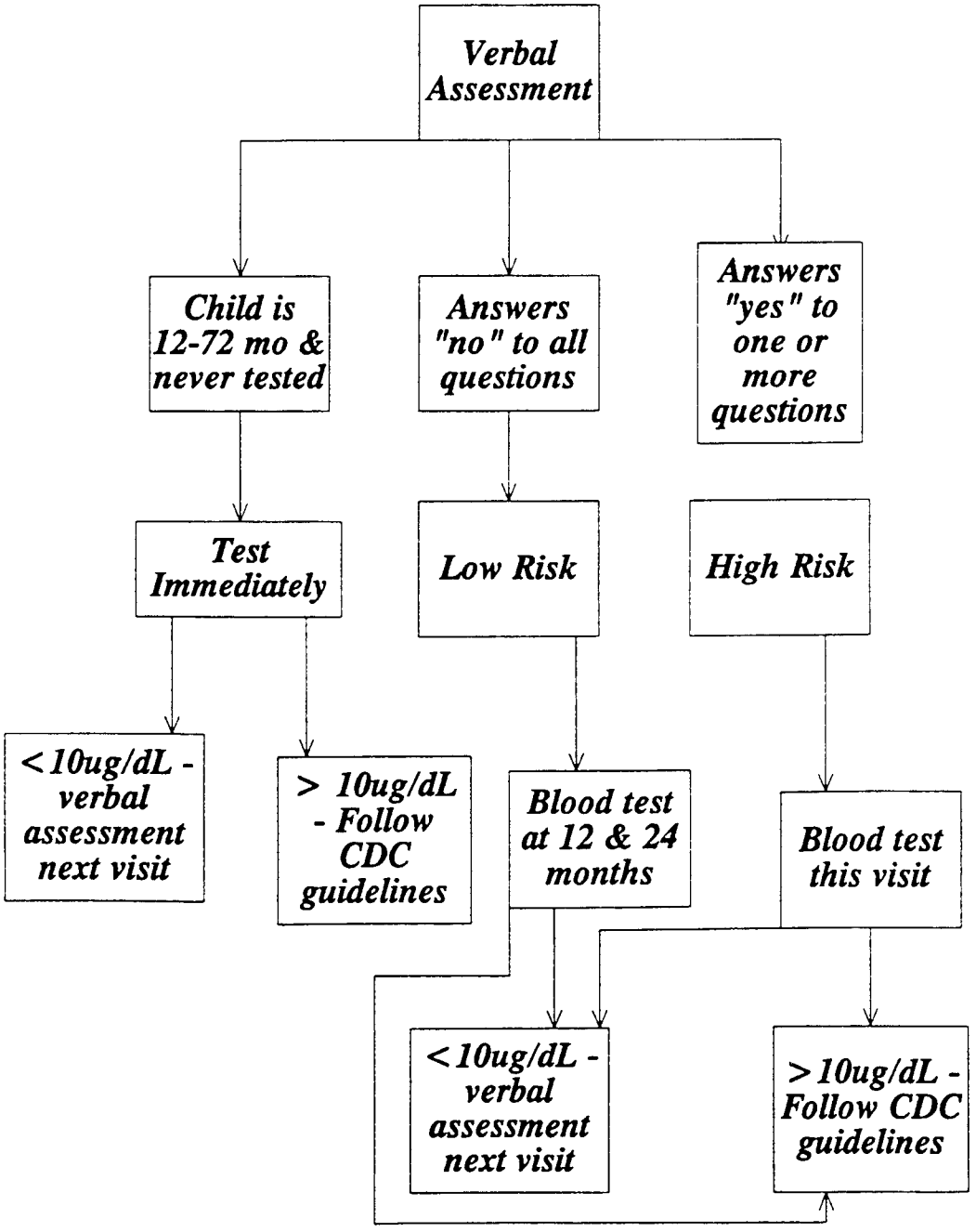
Followup of children with blood lead levels ≥15 μg/dL:
Followup of children with blood lead levels ≥15 μg/dL is briefly summarized below. In general, such children should receive blood lead tests at least every three to four months.

- **If the blood lead level is 15-19 μg/dL,** the child should be screened every three to four months, the family should be given education and nutritional counseling and a detailed environmental history should be taken to identify any obvious sources or pathways of lead exposure. When the venous blood lead level is in this range in two consecutive tests three to four months apart, environmental investigation and abatement should be conducted, if resources permit.

- **If the blood lead level is ≥20 μg/dL,** the child should be given a repeat test for confirmation. If the venous blood lead level is confirmed to be ≥20 μg/dL, the child should be referred for medical evaluation and followup. Such children should continue to receive blood lead tests every three to four months or more often if indicated. Children with blood lead levels ≥45 μg/dL must receive urgent medical and environmental followup, preferably at a clinic with a staff experienced in dealing with this disease. Symptomatic lead poisoning or a venous blood lead concentration ≥70 μg/dL is a medical emergency, requiring immediate inpatient chelation therapy.

APPENDIX 13b
LEAD SCREENING GUIDELINES

LEAD SCREENING (AGE 6-72 MONTHS)



APPENDIX 13c
QUESTIONS FOR LEAD SCREENING - RISK ASSESSMENT

Beginning at six months of age and at each visit thereafter, the provider must discuss with the child's parent or guardian childhood lead poisoning interventions and assess the child's risk for exposure. Ask the following types of questions at a minimum.

- Does your child live in or regularly visit an older house built before 1960? Was your child's day care center, preschool, or babysitter's home built before 1960? Does the house have peeling or chipping paint?
- Does your child live in a house built before 1960 with recent, ongoing or planned renovation or remodelling?
- Have any of your children or their playmates had lead poisoning?
- Does your child frequently come in contact with an adult who works with lead? Examples are construction, welding, pottery (or other trades practiced in your community).
- Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead such as (give examples in your community)?
- Do you give your child any home or folk remedies which may contain lead?
- Does your child live near a heavily travelled major highway where soil and dust may be contaminated with lead?
- Does your home's plumbing have lead pipes or copper with lead solder joints?
- Ask any additional questions that may be specific to situations which exist in a particular community.

If the answer to <u>any</u> question is positive, a child is considered high risk for high doses of lead exposure. One additional question that should also be asked for determining risk is:

- When, if ever, did your child have a blood lead test done?

Source: State Medicaid Manual, Part 5, September, 1992 **Effective Date:** 9/19/92

APPENDIX 14
HIGH RISK FACTORS FOR HEARING LOSS IN NEONATES AND INFANTS

HIGH RISK FACTORS FOR HEARING LOSS IN NEONATES AND INFANTS

In 1990 the Joint Committee on Infant Hearing*, in response to recent research and new legislation (P.L. 99.457), expanded and clarified the risk criteria for hearing loss they proposed in 1982. Because moderate to severe sensorineural hearing loss can be confirmed in 2.5% to 5.0% of neonates manifesting any of the previously published risk criteria, audiological testing of this group by six months of age is warranted. The Program for Children with Special Health Care Needs (CSHCN) recommends that neonates or infants who have one or more of the risk factors should be referred to a qualified audiologist for hearing screening.

A. **Risk Criteria: Neonates (birth - 28 days)**
The risk factors that identify those neonates who are at-risk for sensorineural hearing impairment include the following:

1. **Family history of congenital or delayed onset childhood sensorineural impairment.
2. Congenital infection known or suspected to be associated with sensorineural hearing impairment such as toxoplasmosis, syphilis, rubella, cytomegalovirus and herpes.
3. Craniofacial anomalies including morphologic abnormalities of the pinna and ear canal, absent philtrum, low hairline, et-cetera.
4. Birth weight less than 1500 grams (-3.3 lbs.).
5. Hyperbilirubinemia at a level exceeding indication for exchange transfusion.
6. Ototoxic medications including but not limited to the aminoglycosides used for more than 5 days (e.g., gentamicin, tobramycin, kanamycin, streptomycin) and loop diuretics used in combination with aminoglycosides.
7. Bacterial meningitis.
8. Severe depression at birth, which may include infants with Apgar scores of 0-3 at 5 minutes or those who fail to initiate spontaneous respiration by 10 minutes or those with hypotonia persisting to 2 hours of age.
9. Prolonged mechanical ventilation for a duration equal to or greater than 10 days (e.g., persistent pulmonary hypertension).
10. Stigmata or other findings associated with a syndrome known to include sensorineural hearing loss (e.g., Waardenburg or Usher's Syndrome).

B. **Risk Criteria: Infants (29 days - 2 years)**
The factors that identify those infants who are at-risk for sensorineural hearing impairment include the following:

1. Parent/caregiver concern regarding hearing, speech, language, and/or developmental delay.
2. Bacterial meningitis.
3. Neonatal risk factors that may be associated with progressive sensorineural hearing loss (e.g., cytomegalovirus, prolonged mechanical ventilation and inherited disorders).
4. Head trauma especially with either longitudinal or transverse fracture of the temporal bone.
5. Stigmata or other findings associated with syndromes known to include sensorineural hearing loss (e.g., Waardenburg or Usher's Syndrome).
6. Ototoxic medications including but not limited to the aminoglycosides used for more than 5 days (e.g., gentamicin, tobramycin, kanamycin, streptomycin) and loop diuretics used in combination with aminoglycosides).
7. Children with neurodegenerative disorders such as neurofibromatosis, myoclonic epilepsy, Werdnig-Hoffman disease, Tay-Sach's disease, infantile Gaucher's disease, Nieman-Pick disease, any metachromatic leukodystrophy, or any infantile demyelinating neuropathy.
8. Childhood infectious diseases known to be associated with the sensorineural hearing loss (e.g., mumps, measles).

*The 1990 Joint Committee was represented by the following: American Speech-Language-Hearing Association; American Academy of Otolaryngology-Head and Neck Surgery; American Academy of Pediatrics; Council on Education of the Deaf; Directors of Speech and Hearing Programs in State Health and Welfare Agencies.

**This criteria pertains ONLY to relatives of the child who had a permanent hearing loss which began in the first five years of life, and required the use of a hearing aid and/or special education.

APPENDIX 14a

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Division of Health
DOH 1067 (5/91)

STATE OF WISCONSIN

YOUR CHILD'S SPEECH AND HEARING

INSTRUCTIONS: Read each question through the child's age group and check YES or NO. Add the total number of NOs. If you obtain 2 or more NOs within an age level, or three or more NOs in all age groups through the child's age group refer for audiological and communicative screening/assessment.

Check One ✔ YES	Check One ✔ NO	Hearing and Understanding	Child's Age	Talking	Check One ✔ YES	Check One ✔ NO
		Does your child listen to speech? Does your child startle or cry at noises? Does your child awaken at loud sounds?	**BIRTH** 	Does your child make pleasure sounds? When you play with your child, does he/she look at you, look away, & then look again?		
		Does your child turn to you when you speak? Does your child smile when spoken to? Does your child seem to recognize your voice and quiet down if crying?	**0-3 MONTHS** 	Does your child repeat the same sounds a lot (cooing, gooing)? Does your child cry differently for different needs? Does your child smile when he/she sees you?		
		Does your child respond to "no"? Changes in your tone of voice? Does your child look around for the source of new sounds, e.g., the doorbell, vacuum, dog barking? Does your child notice toys that make sound?	**4-6 MONTHS** 	Does your child's babbling sound more speech-like with lots of different sounds, including *p*, *b*, and *m*? Does your child tell you (by sound or gesture) when he/she wants you to do something again? Does your child make gurgling sounds when left alone? When playing with you?		
		Does your child recognize words for common items like "cup," "shoe," "juice"? Has your child begun to respond to requests ("come here," "want more?")?	**7 MONTHS-1 YEAR** 	Does your child have 1 or 2 words (bye-bye, dada, mama, no) although they may not be clear?		
		Does your child enjoy games like peek-a-boo and pat-a-cake? Does your child turn or look up when you call his or her name? Does your child listen when spoken to?		Does your child's babbling have both long and short groups of sounds such as "tata upup bibibibi"? Does your child imitate different speech sounds? Does your child use speech or non-crying sounds to get and keep your attention?		

APPENDIX 14a
YOUR CHILD'S SPEECH AND HEARING
(continued)

Check One ✔ YES	Check One ✔ NO	Hearing and Understanding	Child's Age	Talking	Check One ✔ YES	Check One ✔ NO
		Can your child point to pictures in a book when they are named? Does your child point to a few body parts when asked? Can your child follow simple commands and understand simple questions ("Roll the ball," "Kiss the baby," "Where's your shoe?")? Does your child listen to simple stories, songs, and rhymes?	**1-2 YEARS** 	Is your child saying more and more words every month? Does your child use some 1-2 word questions ("where kitty?" "go bye-bye?" what's that?")? Does your child put 2 words together ("more cookie," "no juice," "mommy block")? Does your child use many different consonant sounds at the beginning of words?		
		Does your child understand differences in meaning ("go-stop"; "in-on"; "big-little"; "up-down")? Does your child continue to notice sounds (telephone ringing, television sound, knocking at the door)? Can your child follow two requests ("get the ball and put it on the table")?	**2-3 YEARS** 	Does your child have a word for almost everything? Does your child use 2-3 word "sentences" to talk about and ask for things? Do you understand your child's speech most of the time? Does your child often ask for or direct your attention to objects by naming them?		
		Does your child hear you when you call from another room? Does your child hear television or radio at the same loudness level as other members of the family? Does your child answer simple "who," "what," "where," "why" questions?	**3-4 YEARS** 	Does your child talk about what he/she does at school or a friends' homes? Does your child say most sounds correctly except a few, like *r, l, th* and *s*? Does your child usually talk easily without repeating syllables or words? Do people outside your family usually understand your child's speech? Does your child use a lot of sentences that have 4 or more words?		
		Does your child hear and understand most of what is said at home and in school? Does everyone who knows your child think he/she hears well (teacher, baby sitter, grandparent, etc.)? Does your child pay attention to a story and answer simple questions about it?	**4-5 YEARS** 	Does your child communicate easily with other children and adults? Does your child say all sounds correctly except maybe one or two? Does your child use the same grammar as the rest of the family? Does your child's voice sound clear like other children's? Does your child use sentences that give lots of details (e.g., "I have two red balls at home")? Can your child tell you a story and stick pretty much to the topic?		
		Total		**Total**		

APPENDIX 15
SCREENING SCHEDULE FOR PEDIATRIC EYE PROBLEMS

Screening schedule for pediatric eye problems

By incorporating the following screening procedures into your program of well-child checks, you'll be able to make the earliest possible referrals for strabismus, amblyopia, and other serious eye problems, which you may encounter.

Age	Recommended procedures	Refer to an ophthalmologist if you find:
Newborn (nursery exam)	Consider history, examine external ocular structures. Assess infant's ability to follow your face. Perform red reflex gemini test. Try to examine fundi.	Any impediment to flow of light to the retina, infection, malformation, corneal abnormalities, or photophobia.
2 months	Check external ocular structures. Perform red reflex gemini test. Test pupillary reflexes.	Any condition listed above or abnormal pupillary response.
3 - 4 months	Ask parent if child's eyes always seem aligned and appear to be working together. Examine external ocular structures. Perform red reflex gemini/corneal light reflex test and cover test. Test pupillary reflexes.	Any condition listed above.*
6 months	Update history. If history is negative, perform red reflex gemini/corneal light reflex test and cover test, test pupillary reflexes and examine fundi.	Any condition listed above or any indication of misalignment or abnormal eye movement.
6 months to 2 - 3 years	Update history. Perform red reflex gemini/corneal light reflex test and cover test.	Any condition listed above.
2 - 3 years (when child begins to become verbal)	Update history. If negative, perform red reflex gemini/corneal light reflex test and cover test. Test visual acuity in each eye separately with Allen picture cards.	Any condition listed above or test results suggesting a great difference in visual acuity between the two eyes.**
3 - 4 years (approximately)	Same as above, but consider using E game or HOTV chart to test visual acuity.	Any condition listed above.**
5 years (or when child becomes literate)	Same as above, but consider using a standard Snellen's chart to assess visual acuity.	Any condition listed above.**

*You might want to refer if you find any indication of misalignment or abnormal eye movement; at least plan to recheck your finding before 6 months of age.
**A difference of 5 ft in the Allen picture card test or of two lines in the E game, HOTV chart, or Snellen's chart indicates a significant difference in visual acuity.

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE

SECTION A - Resources Available from EDS

1. Bureau of Health Care Financing Publications - The following publications may be obtained by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

   a. Wisconsin Medical Assistance Provider Handbook
   Handbooks include procedure guidelines and billing instructions for all providers and for specific provider types in the Wisconsin Medical Assistance Program. Do not send orders to the Bureau of Health Care Financing.

   b. Maximum Allowable Fee Schedules
   Procedure codes and maximum allowable fees for specific provider types participating in the Wisconsin Medical Assistance Program.

   c. Provider Bulletins (A Subscription Service)
   A set of individual bulletins issued periodically. Current information regarding changes or clarifications of new and existing Medical Assistance policies and procedures.

   * Fee

SECTION B - Resources Available Directly from State Agencies

1. DEPARTMENT OF HEALTH AND SOCIAL SERVICES

   a. Bureau of Health Care Financing Publications* - Available from the Bureau of Health Care Financing at the address listed below.

	Document #
- HealthCheck Outreach/Case Management Providers by County	
- HealthCheck Individual Health History Form	DOH 1002
- HealthCheck Brochure (English)	POH 1007
- HealthCheck Brochure (Spanish)	POH 1007S
- HealthCheck Brochure (Hmong)	POH 1007H
- Oral Assessment Instruction	POH 1038
- HealthCheck Periodicity Table	DOH 1061
- HealthCheck Adolescent Review Form	DOH 1062
- HealthCheck Family History	DOH 1063
- Infant Food Record (0-12 Months of Age)	DOH 1066
- Child's Food Record (1-12 Years of Age)	DOH 1066A
- Adolescent Food Record (13-20 Years of Age)	DOH 1066B
- Your Child's Speech and Hearing	DOH 1067
- Daily Food Suggestions for Infants	POH 1030
- Modified Basic Four Food Groups	POH 1031
- Screening Schedule for Pediatric Eye Problems	POH 1033
- Preventing Childhood Lead Poisoning	POH 4535
- Renovating Your House	POH 4529

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

Section B - Resources Available Directly from State Agencies (continued)

- HealthCheck Poster (8 1/2 x 14")	POH 1041
- HealthCheck Check Stuffer/Handbill	POH 1041A
- HealthCheck Bus Poster (14 x 28)	POH 1041B
- HealthCheck Stickers	POH 1041C
- HealthCheck Logo Sheet	POH 1041D
- HealthCheck Periodicity Poster	POH 1042
- HealthCheck Note Pad	DOH 1103
- HealthCheck Verification Card (100/packet)	DOH 1112

Age Specific HealthCheck Documentation Forms* (by Memee K. Chun, M.D.)

- 3-4 Weeks	DOH 1068A
- 6-8 Weeks	DOH 1068B
- 4 Months	DOH 1068C
- 6 Months	DOH 1068D
- 9 Months	DOH 1068E
- 12 Months	DOH 1068F
- 15 Months	DOH 1068G
- 18 Months	DOH 1068H
- 24 Months	DOH 1068I
- 3-5 Years (preschool)	DOH 1068J
- 6-12 Years (elementary school)	DOH 1068K
- 13-20 Years (teenage)	DOH 1068L
- Teenager Confidential Health Survey	DOH 1068M

* No Charge

Available from: Wisconsin Division of Health
Bureau of Health Care Financing
Forms Publication
Post Office Box 309
Madison, WI 53701-0309

b. Family and Community Health - Maternal and child health materials are available from Wisconsin's Division of Health - Family and Community Health, Family Health Unit, at the address listed below.

- Report of the Second Task Force on Blood Pressure Control in Children (1987)
- Chlamydia Trachomatis Risk Assessment Checklist and Policies/Protocols.
- Nutrition Screening and Assessment Manual (0-5 Years)
- Family Health Resource Catalog and order form

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

Section B - Resources Available Directly from State Agencies (continued)

- Helping Baby Grow: Month by Month (Parents) - A food guide for parents of children 1-5 years of age #4029
- The first 12 months: A guide to feeding your baby (Parents) #4030
- Healthy Teeth for Happy Smiles (Parents) - A dental pamphlet for parents of infants and young children #4078

* No Charge

Available From: Wisconsin Division of Health
Bureau of Public Health
Family Health Unit
1 West Wilson Street
Post Office Box 309
Madison, WI 53701-0309

c. Division of Community Services

- Licensing Rules for Group and Family Day Care Centers (10/84)

Available From: Wisconsin Division of Community Services
1 West Wilson Street, Room 465
Madison, WI 53701

d. Bureau of Public Health, Communicable Disease Prevention and Control Unit

- Information and Recommendations for child care and pediatric AIDS, HIV Infections and Related Conditions #4200
- Educators Guide to AIDS & Other STD's #4263

Available from: Wisconsin Division of Health
Bureau of Public Health
Communicable Disease Prevention and Control Unit
1414 E. Washington Avenue
Madison, WI 53703-3044

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

Section B - Resources Available Directly from State Agencies (continued)

2. DEPARTMENT OF PUBLIC INSTRUCTION

	Document #
- A Guide to Curriculum Planning in Health Education (1987 Reprint)	#6102
- Instructions about AIDS in Wisconsin Schools (1988)	#8248
- Dealing with Child Sexual Assault and Abuse: A Resource and Planning Guide (1989 Reprint)	#6509
- Suicide Prevention: A Resource and Planning Guide (1988 Reprint)	#6517
- Educational Assessment of Emotional Disturbance: An Evaluation Guide (1990)	#0452

All Orders Must be Accompanied by Personal Check or Money Order, or call with Visa or Master Card Orders. Catalog Available.

Available From: Publications Sales
Wisconsin Department of Public Instruction
Drawer 179
Milwaukee, WI 53293-0179
Customer Service: (800) 243-8782
Fax: (608) 267-1052

SECTION C - Resources Available from National Organizations

1. National Society for the Prevention of Blindness

- Guidelines for School and Preschool Vision Screening. Reprint available after 4/91.

a. Prevent Blindness - Wisconsin

- Most Current Guidelines Used Throughout the State

* Fee

Available From: National Society to Prevent Blindness
759 North Milwaukee Street
Milwaukee, WI 53202
(414) 765-0505

2. American Heart Association

- Cholesterol Tracking Record

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

SECTION C - **Resources Available from National Organizations** (continued)

- Prevention of Rheumatic Fever: A Statement for Health Professionals (1988 Revised)
- Diet in the Healthy Child (1983)
- Dietary Treatment for High Blood Pressure and High Cholesterol for the Patient
- Dietary Treatment for Increased Blood Pressure and Increased Cholesterol for the Counselors

Available From: American Heart Association
795 North Van Buren Street
Milwaukee, WI 53202
1-800-242-9236

3. American Academy of Pediatrics

	Document #
- Guidelines for Health Supervision - 2nd Edition (1988) Spiral bound, 22 cue cards	MA 0021*
- Substance Abuse: A Self-Teaching Guide for Health Professionals (1988) Softcover	MA 0036*
- Adolescent Sexuality: Guides for Professional Involvement (1988). Two-volume - 3 Ring Binder Set.	MA 0040
- Pediatric Nutrition Handbook - 2nd Edition (1985)	MA 0020
- Child Sexual Abuse: What It Is and How to Prevent It (100 copies)	HE 0029*
- Health Care for Children of Migrant Families (10/89)	HE 9166
- Health Needs of Homeless Children (12/88)	RE 8124
- Adolescent Health Update - Physical Assessment of Early Adolescent (Tanner Sex Maturity Ratings - 1989)	HE 0091

* Member and Nonmember fee(s).

Available From: Publications Department
141 Northwest Point Boulevard
Post Office Box Box 927
Elk Grove Village, IL 60009-0927
(708) 228-5005 (Catalog available)

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

SECTION C - Resources Available from National Organizations (continued)

U.S. GOVERNMENT PRINTING OFFICE

- Federal Health Services Publications Catalog

  Available From: U.S. Government Printing Office
  Washington, DC 20402-9325
  (202) 783-3238 (Order and Information Desk)
  (202) 275-3634 (For Updates on Publications)

  * No Charge

- Health Information Resources in Federal Government: Year 2000 Priorities - 5th Edition (1991)

  * Fee

  Available From: National Center for Health Information
  Post Office Box 1133
  Washington, DC 20013-1133
  Telephone: 1-800-336-4797
  301-565-4167

JOHN MUIR MEDICAL CENTER - A catalog of entries (613 audiovisuals) is available from John Muir Medical Center at the address listed below.

- Babies at Risk - The Growing Tragedy of Babies Being Born Malnourished or Drug Addicted
- The Miracle of Birth
- New Parents, New Baby
- Parents Guide to Quality Child Care

* Fee

Available From: John Muir Medical Center
1601 Ygnacio Valley Road
Walnut Creek, CA 94598
(415) 947-5303
Fax: (415) 947-5341

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

SECTION C - Resources Available from National Organizations (continued)

OTHER RESOURCES

- W.I.C. (Women's, Infant's and Children's). WIC Referral Forms are available from the WIC Program Project or your local Health Department

- Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing Vol. 1 and 2 (1987) * Catalog Available

Available From: National Academy Press
Publications Division of National Academy of Science
2101 Constitution Avenue Northwest
Washington, DC 20418
Attn: Order Department
Telephone: (202) 334-2000

- Mentoring Manual/Handbook: A guide to Program Development and Implementation (1989) Resource for mentoring disadvantaged youth

* Fee, no purchase orders or charges accepted.

Available From: Abell Foundation
210 North Charles Street #1116
Baltimore, MD 21201
(301) 547-1300

- Teaching Decision Making to Adolescents: A Critical Review (1989)

* Publication List Available

Available From: Carnegie Council on Adolescent Development
2400 North Street Northwest Floor 6
Washington, DC 20036
Telephone: 202-429-7979
Fax: 202-775-0134

- Make a Life for Yourself (1988 Revision) * Catalog Available

* Minimal Cost

Available From: Center for Population Options
1025 Vermont Avenue Northwest #210
Washington, DC 20005
Telephone: (202) 347-5700

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

SECTION C - **Resources Available from National Organizations** (continued)

- Safe State, Safe Teen Counseling Guide (1989)

Available From: Massachusetts Dept. of Public Health
Statewide Comprehensive Injury Prevention Program
150 Tremont Street, 3rd Floor
Boston, MA 02117
Telephone: (617) 727-1246

MODEL ADOLESCENT HEALTH SCREENING/ASSESSMENT TOOLS

- Health History and Physician Exam

Available From: Operation Fresh Start
Attn: Susan Bunge-Quigley
1925 Winnebago Street
Madison, WI 53704
Telephone: (608) 244-4721

- Adolescent Review (History Supplement)

Available From: Wisconsin Division of Health
Attn: Family and Community Health Section
Post Office Box 309
1 West Wilson Street
Madison, WI 53701-0309
Telephone: (608) 266-0220

- Adolescent Health Risk Appraisal

Available From: Waukesha County Department of Health
Attn: Beth Heller
325 East Broadway
Waukesha, WI 53186
Telephone: (414) 549-3012

- Teen Health Assessment Form - Teen Health Services

Available From: LaCrosse Lutheran Hospital
Attn: Brian Theiker - Teen Health Service
1910 South Avenue
LaCrosse, WI 54601
Telephone: (608) 785-0530

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

SECTION C - Resources Available from National Organizations (continued)

ADOLESCENT NEEDS ASSESSMENT TOOLS LISTED IN WISCONSIN

Youth Risk Behavior Survey - Center for Disease Control. This tool was administered by the Department of Public Instruction to a sampling of grades 9-12 in the Spring of 1990.

Available From: Department of Public Instruction
Attn: Barbara Nehls-Lowe
125 South Webster Street, 4th Floor
Madison, WI 53707

Teen Assessment Project - University of Wisconsin Extension
Through a statewide youth initiative, the cooperative extension works with schools and communities to do a needs assessment and analysis of data. Surveys were completed in schools in the following counties:

Juneau	Oconto	Grant
Clark	Adams	Ashland
Forest	Florence	Jefferson
Oneida	Vilas	Langlade
Marathon		

* Minimal cost

Available From: University of Wisconsin
Department of Child and Family Studies
Attn: Stephen Small
Madison, WI 53706

or

Contact your local Cooperative Extension agent.

SECTION D - Other

Referral Forms:
HealthCheck referral forms can be obtained by submitting a written request to:

EDS
Attn: Claim Reorder
6406 Bridge Road
Madison, WI 53784-0003

(continued)

APPENDIX 16
HEALTHCHECK RESOURCE GUIDE
(continued)

SECTION C - Resources Available from National Organizations (continued)

**Allen Picture Cards For use in doing vision testing with 2-3 year olds. May be ordered from:

Herslof Optical
University Station Clinics
2880 University Avenue
Madison, WI 53705

** There is a charge for these cards.

Denver 2 Developmental Kit

Denver Developmental Materials, Inc.
P.O. Box 6919
Denver, CO 80206-0919
Telephone: (303) 355-4729

* There is a charge for this kit.

APPENDIX 17
HEALTHCHECK SERVICES CODES

ALLOWABLE PLACE OF SERVICE

Code	Description
0	Other
2	Outpatient Hospital
3	Office
4	Home

ALLOWABLE TYPE OF SERVICE

Code	Description
1	Medical
5	Lab
9	Other

NOTE: Refer to Appendix 18a and 18b to identify allowable place of service and type of service codes for specific HealthCheck procedure codes.

APPENDIX 18a
SCREENING PROCEDURE CODES
WITH ALLOWABLE CLAIM SORT INDICATORS AND MODIFIERS
FOR CLAIMS RECEIVED BY THE FISCAL AGENT DURING THE TRANSITION PERIOD
(FROM 2/15/95 THROUGH 6/30/95)

H" CLAIM SORT INDICATOR

Procedure Code	Description	POS	TOS	Claim Sort	Modifiers
W7000	Comprehensive Screen	0,2-4	1	H	01-07, 09-12, 14-20
W7002	Vision Test	0,2-4	1	H	01-03, 05-06, 09-10, 12, 19-20
W7003	Hearing Test	0,2-4	1	H	01-03, 06-07, 10, 12, 15, 19-20
W7009	Oral Assessment	0,2-4	1	H	01-04, 06, 12, 14, 19-20
W7010	Pelvic Exam	0,2-4	1	H	01-03, 06, 16-17
W7013	Interperiodic; Brief	0,2-4	1	H	01-07, 09-12, 14-20
W7015	Interperiodic; Intermediate	0,2-4	1	H	01-07, 09-12, 14-20
W7016	Interperiodic; Extended	0,2-4	1	H	01-07, 09-12, 14-20
W7017	Educational Visit, Lead Poisoning	0,3,4	1	P	None
W7083	Environmental Lead Inspection (initial)	4	9	P	None
W7084	Environmental Lead Inspection (follow-up)	4	9	P	None

OR

"P" CLAIM SORT INDICATOR

Procedure Code	Description	POS	TOS	Claim Sort	Modifiers
99381-5	Initial Evaluations	0,3,4	1	P	MR, VH, NO/HA, HB, HC
99391-5	Periodic Evaluations	0,3,4	1	P	MR, VH, NO/HA, HB, HC
W7002	Vision Test	0,3,4	1	P	None
W7003	Hearing Test	0,3,4	1	P	None
W7009	Oral Assessment	0,3,4	1	P	None
W7010	Pelvic Exam	0,3,4	1	P	None
W7013	Interperiodic; Brief	0,3,4	1	P	None
W7015	Interperiodic; Intermediate	0,3,4	1	P	None
W7016	Interperiodic; Extended	0,3,4	1	P	None
W7017	Educational Visit, Lead Poisoning	0,3,4	1	P	None
W7083	Environmental Lead Inspection (initial)	4	9	P	None
W7084	Environmental Lead Inspection (follow-up)	4	9	P	None

APPENDIX 18b
SCREENING PROCEDURE CODES WITH ALLOWABLE CLAIM SORT INDICATORS AND MODIFIERS FOR CLAIMS RECEIVED BY THE FISCAL AGENT ON OR AFTER 7/1/95

Procedure Code	Description	POS	TOS	Claim Sort	Modifiers
99381-5	Initial Evaluations	0,3,4	1	P	MR, VH, NO or HA, HB, HC
99391-5	Periodic Evaluations	0,3,4	1	P	MR, VH, NO or HA, HB, HC
W7002	Vision Test	0,3,4	1	P	None
W7003	Hearing Test	0,3,4	1	P	None
W7009	Oral Assessment	0,3,4	1	P	None
W7010	Pelvic Exam	0,3,4	1	P	None
W7013	Interperiodic, Brief	0,3,4	1	P	None
W7015	Interperiodic, Intermediate	0,3,4	1	P	None
W7016	Interperiodic, Extended	0,3,4	1	P	None
W7017	Educational Visit, Lead Poisoning	0,3,4	1	P	None
W7083	Environmental Lead Inspection (initial)	4	9	P	None
W7084	Environmental Lead Inspection (follow-up)	4	9	P	None

APPENDIX 19
EMC QUESTIONNAIRE

PAPERLESS CLAIMS REQUEST FORM

Please complete this form if you want additional information on electronic billing.

Name: ______________________________

Address: ______________________________

____

____

Medicaid Number: ______________ **Phone #:** ______________________

Contact Person: ______________________________

Type of Service(s) Provided: ______________________________

Estimated Monthly Medicaid Claims Filed: ______________________________

* *

1. Do you currently submit your Medicaid claims on paper? __YES __NO

2. Are your Medicaid claims computer generated on paper? __YES __NO

3. Do you use a billing service? __YES __NO

   If the answer is YES to #2 or #3, please complete the following:

   Name: ______________________ Contact: ______________

   Address: ______________________ Phone #: ______________

   ____

4. Do you have an in-house computer system? __YES __NO

   If YES, type of computer system:

   a. Large main frame (e.g., IBM 360, Burroughs 3800) — Manufacturer: ____________ Model #: ____________

   b. Mini-Computer (e.g., IBM System 34, or 36 TI 990) — Manufacturer: ____________ Model #: ____________

   c. Micro-Computer (e.g., IBM PC, COMPAQ, TRS 1000) — Manufacturer: ____________ Model #: ____________

5. Please send the paperless claims manual for:

   __ magnetic tape submission

   __ telephone transmission (EDS free software) ___ 3-1/2" ___ 5-1/4"

   __ telephone transmission (3780 protocol transmission)

Return To: EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009

APPENDIX 20

State of Wisconsin
Department of Health and Social Services
Division of Health
DOH-1099 (Rev 10/92)

MEDICAL ASSISTANCE VOLUME VACCINE PURCHASE PROGRAM
SHIPPING REPORT AND ORDER FORM

Medical Assistance Volume Vaccine Purchase Program
Shipping Report and Order Form

Your shipment of vaccines is listed below. If you need to change your shipping information or if you need to order additional vaccines, use this form and return it to us. Complete instructions are on the reverse side of the form. If you have questions about this form, call the Immunization Program at (608)-267-5148.

DIVISION OF HEALTH
IMMUNIATION PROGRAM
P.O. BOX 309
MADISON WI 53701-0309

A. Shipping Information

1. Medical Assistance (MA) Provider Name

2. M A Provider Number

3. Contact Person and Telephone Number for Deliveries

4. Shipping Address (include street address, city, state and zip code)

5. Days and hours available to receive shipment:
TUE WED THUR FRI

B. Vaccine(s) Shipment

** FY = July 1 - June 30

C. Vaccine(s) Order

Vaccine Type	Unit	This Shipment (Units)	Lot Numbers	Total Units Shipped This F.Y. **	Total Units Shipped Last F.Y. **		Order Amount (Units)
DTP	15 doses/vial					6. DTP	vials
DTaP	10 doses/vial					7. DTaP	vials
DT(Ped)	10 doses/vial					8. DT(Ped)	vials
Td(Adult)	10 doses/vial					9. Td(adult)	vials
MMR	10 doses/box					10. MMR	box
OPV	10 doses/tray					11. OPV	tray
IPV	1 dose/vial					12. IPV	vials
Hep. B	1 ml/vial					13. Hep. B	ml
Hib	5 doses/vial					14. Hib	vials

Shipment Date:

15. Check one box. (See instructions on reverse.)

☐ If new provider, please check.

☐ Other Instructions.

16. Signature of person completing form

17. Date of Signature

Medical Assistance Volume Vaccine Purchase Program
Shipping Report and Order Form

DOH-1099

This form is used for 3 purposes. Part A includes shipping information. Use Part A to provide current shipping instructions for the receipt of your vaccine shipments. Part B of the form will include information about the shipment when your vaccines are shipped to you. Use Part C of this form to order additional amounts of vaccines.

1. **Medical Assistance Provider Name** – Enter your clinic name, or if you are in individual practice, enter your name as recognized by EDS on the provider file.

2. **Medical Assistance Provider Number** – Enter your clinic billing number as recognized by EDS on the provider file. If you are in individual practice, enter your performing provider number.

3. **Contact Person and Telephone Number for Deliveries** Enter the name and telephone number of the person who will handle vaccine ordering and deliveries. Be sure to include the area code with the telephone number.

4. **Shipping Address** – Enter the street address, city and state. Include a room number if appropriate. Do not use a box number. Most vaccines will be shipped by a delivery agency, such as UPS.

5. **Days and office hours when available to receive shipment** – Enter the office hours when someone will be available to receive shipments of vaccine. Because vaccines must be refrigerated, we cannot ship for a Monday delivery.

6-14. **Vaccine(s) Order Amount** – Enter the number of *units* for each vaccine; for Hepatitis B, enter the number of *milliliters*.

15. **Check one box.**
New provider. – If you are a new provider or one who has not received vaccine from this program before, check this box and enter your estimated three month need in items 6 - 14.

Other Instructions. – Use this box for any other action. Provide a short explanation.

16. **Signature of person completing this form** – Enter the signature of the person completing this form. If it is different from the contact person listed in item 3, include a printed version of the name.

17. **Date of Completion** – Enter the date when this form is completed and signed.

Shipping Report

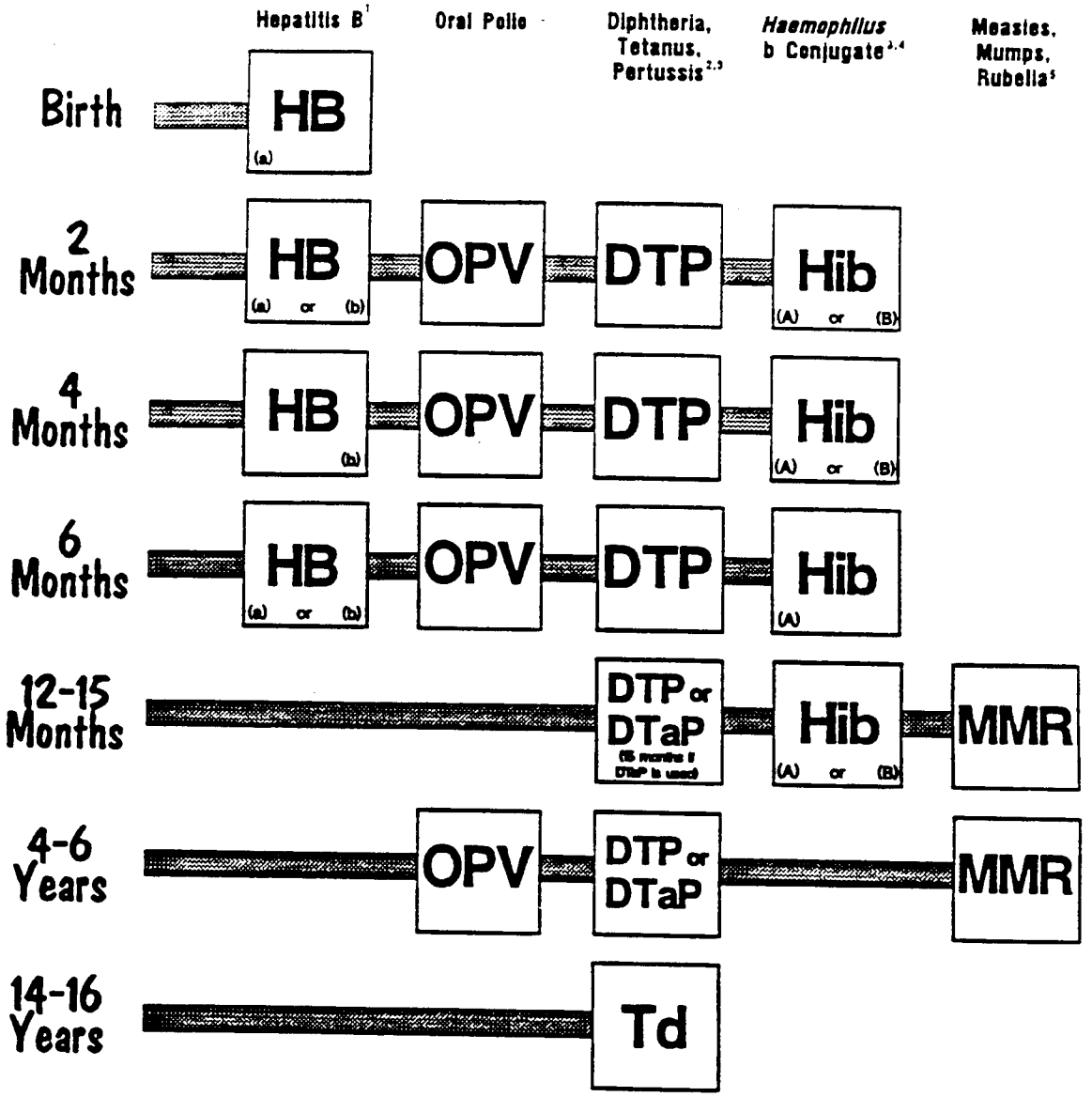
Part B of the form is completed when vaccines are shipped to you. This portion of the form is essentially a packing slip. The vaccines and their unit amounts are listed in columns one and two. The third column includes the number of units in this shipment (for Hepatitis B, number of milliliters). The fourth column lists the lot numbers of the vaccines in the current shipment. The fifth column is your total shipment through the date provided. The sixth column is the total units shipped to you in the previous fiscal year.

Use this form to change your shipping instructions or to order more vaccine.

APPENDIX 21
ACIP RECOMMENDED IMMUNIZATION SCHEDULE

ACIP Recommended Immunization Schedule

9/94



NOTE

- All recommended vaccines may be given simultaneously.
- These recommended ages are not absolute. For example, 2 months can be 6-10 weeks.

[1]Hepatitis B vaccine may be given in either of 2 schedules:
(a) Birth, 1-2 Months, 6-18 Months
(b) 1-2 Months, 4 Months, 6-18 Months

[2]DTP preparation containing acellular pertussis vaccine (DTaP) is recommended for the 4th and 5th doses (for children 15 months of age or older), but whole-cell DTP may still be used if DTaP is not available.

[3]Combination DTP/Hib conjugate vaccine may be used when both shots are scheduled simultaneously.

[4]There are 2 schedules for Hib conjugate vaccines:
(A) HbOC (HibTITER™), PRP-T (ActHIB™), or DTP/HbOC (TETRAMUNE™): 2, 4, 6, & 12-15 Months
(B) PRP-OMP (PedvaxHIB®): 2, 4, & 12-15 Months

[5]The second dose of MMR may be administered at 11-13 years of age.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

APPENDIX 22

ENVIRONMENTAL INSPECTION WORKSHEET

PA/EI

Environmental Inspection Information/Requirements: [Technical aspects of inspection: 1) Determine the most likely sources of high-dose exposure to lead; 2) Investigate the child's home, giving special attention to painted surfaces, dust, soil and water; 3) Advise parents about identified and potential sources of lead and ways to reduce exposure; 4) Notify the property owner immediately that a child residing on the property has lead poisoning; 5) Monitor the effectiveness and timeliness of abatement procedures closely; 6) Coordinate environmental activities with those of other public health and social management agencies.]

Reminder: This form is required when submitting a paper prior authorization request.

Provider Number: _____

Recipient Medicaid Number: _____

Procedure Code: W7083 (Initial Inspection) - press *917083

W7084 (Follow-up Inspection) - press *917084

Type of Service: 9

Diagnosis: 984

Place of Service: _____ (If the child's home, enter 4. If other, enter 0)

Anticipated Date of Service: _____ (Enter MMDDYY)

Quantity Requested: 1

PA Request Checklist

ALL information must be provided in order to be processed.

A) Indicate recipient's blood lead level: _____

Indicate the date(s) of testing (use MMDDYY numeric format): _____

B) Has inspection staff completed DHSS-approved lead inspection training?

1 - Yes 2 - No

An approved prior authorization request allows Wisconsin Medicaid payment for two services. An initial inspection (W7083) and one follow-up inspection (W7084). Where necessary, one interperiodic visit for education related to lead poisoning may be billed. The code for this is W7017.

APPENDIX 23
WISCONSIN STAT PA INSTRUCTIONS TO OBTAIN PRIOR AUTHORIZATION FOR ENVIRONMENTAL LEAD INSPECTIONS

The Wisconsin STAT PA system is an electronic prior authorization system that allows Medicaid certified HealthCheck providers to receive prior authorization electronically rather than by mail. STAT PA allows you to answer a series of questions and receive an immediate response of approval or denial of your prior authorization request.

Providers communicate with the STAT PA system by entering requested information on a touch-tone telephone keypad, a personal computer or verbally through a Help Desk.

The system is available from 8:00 a.m. to 9:00 p.m., Monday through Friday, excluding holidays. Providers must have their eight-digit WMAP provider number to access the system.

How to use STAT PA

1. Complete the Prior Authorization for Environmental Lead Inspection (PA/EI) worksheet. (This serves both as your documentation and worksheet for answering the questions on the STAT PA system.)

2. Select your mode of transmission (touch-tone phone, personal computer, help desk)

   Touch-Tone Phone
   If you want to use a touch-tone phone to submit a prior authorization call:

   1. (800) 947-1197
      or
      (608) 221-2096

   This connects you directly with the STAT PA system.

   2. When the system answers, it will ask a series of questions that you answer by entering the information on the telephone keypad. Your completed worksheet gives you the information you need to answer these questions in the order they'll be asked. NOTE: **When using a touch-tone telephone, providers must always press the pound (#) sign to mark the end of the data just entered.**

   3. Once all data has been entered, STAT PA begins to process the information and, in minutes, "speaks" back either the prior authorization number and the authorized level of service or a denial.

   As providers become familiar with the system, they may enter information in the designated order without waiting for the "speaking" of the question to conclude. The system automatically proceeds to the next field when you do this.

   Personal Computer
   If you want to use a personal computer to submit a prior authorization :

   1. Enter the prior authorization information into the STAT PA software provided FREE by EDS. This software may be obtained electronically through EDS's bulletin board system, EDS-EPIX. Please refer to Appendix 24 of this handbook for instructions on how to access the Bulletin Board. You may also call the Help Desk at (800) 947-1197 or (608) 221-2096 to request software.

   The STAT PA software screens contain all the data fields needed to process the request. Please refer to the STAT PA User Manual for software instructions.

APPENDIX 23
WISCONSIN STAT PA INSTRUCTIONS TO OBTAIN PRIOR AUTHORIZATION FOR ENVIRONMENTAL LEAD INSPECTIONS
(continued)

2. Once all data has been entered, transmit the electronic request to EDS by using a modem and telephone line as is done for electronic claims. For submissions, call:

(800) 947-4947
or
(608) 221-1233

This connects you directly with the STAT PA system.

STAT PA processes the information and, in minutes, generates an electronic confirmation transaction that displays directly on your personal computer screen. The transaction shows what you requested and what the system allowed, as well as the assigned prior authorization number, and grant and expiration dates.

Help Desk
Providers who do not have a touch-tone telephone or a personal computer should call the Help Desk. The Help Desk operator has the personal computer software to access STAT PA and will enter the required data for you. For the Help Desk, call:

(800) 947-1197
or
(608) 221-2096

Record your prior authorization number for use with claim submission:

- Regardless of the way you request prior authorization, you must retain the assigned prior authorization number for use in claim submission.

- Providers also receive, by mail, a confirmation notice indicating the assigned prior authorization number and the STAT PA decision. This confirmation notice should be kept as a permanent record of the transaction.

HELPFUL HINTS

- The provider is given three attempts at each field to correctly enter the requested data.
- Failure to enter any data within 1-1/2 minutes ends the connection.
- You are limited to 5 transactions per connection for telephone or Help Desk and 25 transactions per connection for computers.
- In the event the STAT PA system is unavailable before the inspection is made, you may request backdating of the prior authorization for up to four calendar days.
- The Help Desk is available to all STAT PA users. If you are experiencing difficulties with the system , please call the Help Desk.

APPENDIX 24
HOW TO ACCESS THE BULLETIN BOARD

EDS-EPIX (V 1.1) Quick Guide To Obtaining WMAP STAT PA Information

---

This is a quick guide to retrieving WMAP STAT PA Information using *EDS-EPIX*. If you wish to receive the complete *EDS-EPIX* User Manual, please call EDS at (608) 221-4746, and ask for the EMC Department.

1. Before downloading, we recommend that you create a directory on your hard drive specifically for your STAT PA software. To do this, type the following command at the C:\ prompt:

   MD STATPA <Enter>

2. Set up your communication software to dial *EDS-EPIX*. Along with the telephone number you may need to program your software to dial with the following settings:

Phone Number:	(608) 221-8824	**Stop Bits:**	1
Baud Rate:	9600 (maximum)	**Duplex:**	Full
Parity:	None	**Protocol:**	XMODEM (recommended)
Data Bits:	8	**Terminal Emulation:**	ANSI

3. Dial into *EDS-EPIX*. When you go through this initial logon, you will be asked your first and last names. If you wish, you may logon as follows:

   What is your first name? **STAT**
   What is your last name? **PA**
   What is your password? **WMAP**

4. Select option "T" (Transfer Protocol) from the main menu. Next, select the protocol you wish to use for your download. We recommend that you select Xmodem/CRC as your protocol.

5. Select option "D" (Download a File) from the main menu and type the file name STATSOFT.EXE. Next, tell your communications software package to "Receive a File". If you are unsure of how to do this, follow the download instructions in the user manual for your communications software package. Your communications software will probably ask you for a transfer protocol (choose XMODEM), and a file name. When you type in the name of the file, please include the directory path you created above (e.g. C:\STATPA\STATSOFT.EXE). If you fail to specify the directory path with the file name, the file will be downloaded into the default download directory for your communications software. The download will take from 15-35 minutes depending on the speed of your modem and the clarity of your telephone line.

6. When you have downloaded your file, select "G" (Goodbye) to end your *EDS-EPIX* session, quit your communication software, and return to DOS.

7. Go to the STATPA subdirectory and look for your download file. It should be listed when you list the directory. If the download file is in the directory, you will need to decompress the file*. At the DOS command prompt, type the name of the download file without the ".EXE" extension:

   STATSOFT <Enter>

   * Note: If you did not download the STATSOFT.EXE file to the STATPA directory, copy the file to your STATPA directory before proceeding. To do this, go to the subdirectory where the file was downloaded, and type the following command:

   COPY STATSOFT.EXE C:\STATPA <Enter>

8. This will extract your STAT PA information. The files with the .DOC extension are your manuals. These files are ASCII DOS text files. To print these files, use the DOS Print command: PRINT [filename]. The file will be printed on the print device you specify.